

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016596

STATE FILE NUMBER

FILED JUN 8 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 165

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1-57

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Adair</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kirkville</b>  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>Kirkville</b><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Grim-Smith</b>   |                                  | Length of stay in 1b<br><b>1 day</b>  | d. STREET ADDRESS (If outside, give location)<br><b>413 E. Elm</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Charles James Cunningham</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>5/7/59</b>  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 31, 1884</b>  |
| 9. AGE (In years last birthday)<br><b>74</b>   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Adair County, Mo.</b>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  | 13a. FATHER'S NAME<br><b>G. B. Cunningham</b>   | 13b. MOTHER'S MAIDEN NAME<br><b>Ann Eitel</b>  |
| 14. NAME OF HUSBAND OR WIFE<br><b>Lillie Y. Cunningham</b>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  | 16. SOCIAL SECURITY NO.  |
| 17. INFORMANT<br><b>D. D. Cunningham, Noveinger, Mo.</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis.</b><br>DUE TO (b) <b>Arteriosclerotic heart disease.</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>1 year</b>  |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour . Month, Day, Year<br>a.m.<br>p.m.   |                                  | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |  |
| 21. I attended the deceased from <b>4-7-59</b> , to <b>5-7-59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>5-7-59</b><br>Death occurred at <b>7:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |  |
| 22a. SIGNATURE<br><i>J.B. Jones, M.D.</i>  |                                  | 22b. ADDRESS<br><b>Kirkville, Mo.</b>   | 22c. DATE SIGNED<br><b>5-29-59</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE<br><b>5/10/59</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ringo Point</b>   |
| 23d. LOCATION (City, town, or county)<br><b>Western Adair County, Mo</b>   |                                  | (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>Davis &amp; Davis</b>   |                                  | ADDRESS<br><b>Kirkville</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>5-30-1959</b>   |
| 26. REGISTRAR'S SIGNATURE<br><i>Doris W. Rathff</i>  |                                  |   |  |

vector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

J.B. JONES, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Robert B. Davis* .....

Licensed Embalmer No. *4219* .....  
P. O. Address *Fruitville, Mo* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.