

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 14 1959

59-025065

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3703

STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>10 yrs</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>311 E. 6th St.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>311 E. 6th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>MELVIN</u> Middle <u>A</u> Last <u>CUNNINGHAM</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>29</u> Year <u>1959</u>		
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<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7/24/1917</u>	<b>9. AGE (last birthday)</b> <u>42</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HR</b> Hours <u>  </u> Min. <u>  </u>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>St Joseph Mo</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>St Joseph Mo</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>
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<b>13a. FATHER'S NAME</b> <u>Wilber J. Cunningham</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Hester Jackson</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>—</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> <u>—</u>	<b>17. INFORMANT</b> <u>Delora Lisensky</u> Address <u>804 W 14th KC</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute atherosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH   
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Dr. Noel J. W. ...</u>	<b>22b. ADDRESS</b> <u>6022 Prospect Blvd</u>	<b>22c. DATE SIGNED</b> <u>7-31-59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>	<b>23b. DATE</b> <u>7-31-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Calvary Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kansas City, Kansas</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Peter B. Lapetina, K.C., Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-31-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Neve Minschell</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF U.S. REGISTRAR

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

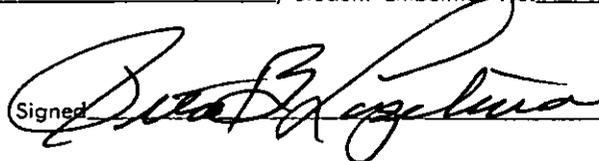
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4273

P. O. Address K.C., 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.