

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS MAR 11 1960

-60-008092
 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 2473**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS, MO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2204 SPRUCE	
3. NAME OF DECEASED (Type or print) BEVERLY ALMEDA CUNNINGHAM		4. DATE OF DEATH FEB. 23, 1960		5. SEX FEMALE	
6. COLOR OR RACE NEGRO		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/23/60	
9. AGE (last birthday)		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO	
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME STILMAN CUNNINGHAM		13b. MOTHER'S MAIDEN NAME MARY ANN ELLIS	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT ST. LOUIS CITY HOSP. #1.		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO (b) _____ DUE TO (c) 776x 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	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 Hour _____ a.m. _____ p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <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 2/23/60		COUNTY		STATE	
21. I attended the deceased from 2 P to 2/23/60 and last saw her/him alive on 2/23/60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE T. James Vaccarella M.D.		22b. ADDRESS 1515 LAFAYETTE AVE	
22c. DATE SIGNED 2/23/60		23a. BURIAL, CREMATION, REMOVAL (Specify) MAR 31 1960		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)	
24. FUNERAL DIRECTOR Rowland Mortuary Svc. 4104-06 Manchester		25. DATE RECD. BY LOCAL REG. MAR 3 1960		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. _____

P. O. Address _____

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.