

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Odin</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>(none)</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED First OTIS Middle PAUL Last CUNNINGHAM

4. DATE OF DEATH Month Oct. Day 23 Year 1960

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-04</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor - Salem Pipe &amp; Supply Co.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ramonia, Oklahoma</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>T. V. Cunningham</u>	13b. MOTHER'S MAIDEN NAME <u>Addie Thompson</u>	14. NAME OF HUSBAND OR WIFE <u>Arlene Cunningham</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>163-09-3968</u>	17. INFORMANT <u>Mrs. Arlene Cunningham, Odin, Ill.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Ventricular standstill</u>		<u>seconds</u>
DUE TO (b) <u>complete heart block</u>		<u>3 days</u>
DUE TO (c) <u>infarction of myocardium (New)</u>		<u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal illness (Specify conditions giving rise to death in PART I.) <u>arteriosclerotic myocardial infarction 3-10-60</u> <u>Anterior lateral myocardial infarction 3/10/60</u>		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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour          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 <u>        </u> COUNTY <u>        </u> STATE <u>        </u>
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21. I attended the deceased from 16 Oct 1947 to 23 Oct 1960 and last saw <sup>her</sup>him alive on 23 Oct 1960

Death occurred at 6:00 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Ray David Williams M.D.</u>	22b. ADDRESS <u>114 N. Taylor</u>	22c. RATE SIGNED <u>10-24-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>Salem, Ill.</u>
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24. FUNERAL DIRECTOR <u>Ples Wilson,</u>	ADDRESS <u>Odin, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 24 1960</u>	26. REGISTRAR'S SIGNATURE <u>Karl Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 10 1961

**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 Mat Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joseph J. Kossly  
Licensed Embalmer No. 734

P. O. Address E. St. L.

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.