

FILED MAR 27 1961

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-61-009944  
STATE FILE NUMBER

Registration District No. 254 Primary Registration District No. 5863 Registrar's No. 12

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Oregon</u> <u>0750</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY <u>Fulton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Couch</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Couch</u>		Length of stay in lb <u>1 Month</u>	d. STREET ADDRESS (If outside, give location) <u>Gen. Del.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Benjamin</u> Last <u>Cunningham</u>			4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1886</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Camp, Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Alfred Mitchell Cunningham</u>	13b. MOTHER'S MAIDEN NAME <u>Loise Francis Tiller</u>	14. NAME OF HUSBAND OR WIFE <u>David R. Cunningham</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT <u>David R. Cunningham</u>	Address <u>Salem, Arkansas</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Bleeding peptic ulcer</u> <u>540.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		DUE TO (c) <u>Cochexia</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				

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 <u>  </u> Month, Day, Year <u>  </u> a.m. <u>  </u> p.m. <u>  </u>			

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>Camp</u>	COUNTY <u>Arkansas</u>	STATE <u>Arkansas</u>
21. I attended the deceased from <u>3-1-61</u> to <u>3-12-61</u> and last saw her/him alive on <u>3-12-61</u> Death occurred at <u>  </u> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Ar Walker</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Mammoth Spring Ark</u>		22c. DATE SIGNED <u>3-23-61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 14, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Camp Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Camp Arkansas</u>
24. FUNERAL DIRECTOR <u>Bryson Funeral Home</u> ADDRESS <u>Mammoth Spring, Ark.</u>		25. DATE RECD. BY LOCAL REG. <u>3-23-61</u>	26. REGISTRAR'S SIGNATURE <u>Arthur Wolf</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949. Doctor, coroner, etc. must use only standard non-enclosure in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Glenn Byson* .....

Licensed Embalmer No. *980* .....

P. O. Address *W. W. Smith, Springfield, 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.