SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-024757

STATE FILE NUMBER

Dr. Park

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 220

FILED AUG 7 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY: GREENE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SPRINGFIELD — Length of stay in 1b: 60 YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 925 W. WALNUT — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: GREENE
c. CITY OR TOWN: SPRINGFIELD — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 925 W. WALNUT — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MARY Middle W. Last CUNNINGHAM
4. DATE OF DEATH: Month JULY Day 29 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 7/11/79
9. AGE (last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): NEWTONIA, MO.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: LEWIS MARSHALL WILLIAMS
13b. MOTHER'S MAIDEN NAME: NANCE C. WEEMS
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
17. INFORMANT: R.D. CUNNINGHAM, SPRINGFIELD, MO. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction due to
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Coronary Thrombosis
DUE TO (c) Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ None
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year None
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Nov. 1959, to 7-29-61 and last saw her alive on 7-29-61
Death occurred at 6 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. Park, M.D.
22b. ADDRESS: 609 Cherry, Springfield Mo
22c. DATE SIGNED: 7/29/61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 7/31/61
23c. NAME OF CEMETERY OR CREMATORY: HAZELWOOD
23d. LOCATION (City, town, or county) (State): SPRINGFIELD, MO.

24. FUNERAL DIRECTOR: H.H. LOHMEYER FUNERAL HOME — ADDRESS: SPRINGFIELD, MO.
25. DATE RECD. BY LOCAL REG.: 8-6-61
26. REGISTRAR'S SIGNATURE: Effie G. Mellor

(Licensed Embalmer's Statement on Reverse Side)

AUG 7 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 me

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 2777

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.