

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-047636

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 204

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1967

VS 300 Rev. 4/59

1 0611
2 0610
3 1
4 1
5 1
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7 0
8 2
9 4201
10
11
12 1-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>MACON</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MACON</u>		Length of stay in lb <u>7 Days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>MACON</u>		c. CITY OR TOWN <u>CALLAO.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SAMARITAN</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LURILE</u> Middle <u>CUNNINGHAM</u> Last						4. DATE OF DEATH Month <u>Dec</u> Day <u>21</u> Year <u>1962</u>					
5. SEX <u>Female</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>7-23-1905</u>		9. AGE (last birthday) <u>57</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>Callao, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>JAMES WHITE</u>				13b. MOTHER'S MAIDEN NAME <u>SALLY KEE</u>				14. NAME OF HUSBAND OR WIFE <u>Aubrey Cunningham</u>			
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>---</u>		17. INFORMANT <u>Aubrey Cunningham, Callao, Mo.</u> 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) <u>Acute coronary occlusion</u>										INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____											
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. <u>MINOR GYN</u> <input type="checkbox"/> Yes <input checked="" 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 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 checked="" type="checkbox"/>		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 <u>12-14-62</u> to <u>12-21-62</u> and last saw her/him alive on <u>12-21-62</u> Death occurred at <u>2:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>James E. Cunningham M.D.</u> (Degree or title)						22b. ADDRESS <u>Marion Mo.</u>			22c. DATE SIGNED <u>12/20/62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-23-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bucklin, Missouri</u>					
24. FUNERAL DIRECTOR <u>Larson Funeral Service, Bucklin, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>12/30/62</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Neely</u>					

USE BLACK INK OR TYPEWRITER RIBBON

0217

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,

X or by Larry D. Vobornik, Student Embalmer No. 669

working under my personal supervision.

Student Larry D. Vobornik
Signature of Student Embalmer

Signed C. A. Parson

Licensed Embalmer No. 4037

P. O. Address Bucklin, Missouri

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.

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MISSOURI STATE BOARD OF HEALTH