10

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27367

Registration District No. 791 REC'D SEP 14 1939

Primary Registration District No.

Registrar's No. 6867

1. PLACE OF DEATH: 1003

(a) County 2

(b) City or town St Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2844 Locust St (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 2 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St Louis (If outside city or town limits, write "RURAL") 21

(d) Street No. 2844 Locust St (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mahaley Cunningham 552

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased 2 (Month) 2 (Day) 1891 (Year)

8. AGE: Years 48 Months 6 Days 0 If less than one day hr. min.

9. Birthplace Sereeport (City, town, or county) La. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) ? (State or foreign country)

MOTHER
14. Maiden name Emma George
15. Birthplace Unknown (City, town, or county) ? (State or foreign country)

16. (a) Informant's own signature [signature]

(b) Address 2844 Locust St

17. (a) ~~Removal~~ Burial (Burial, cremation, or removal) (b) Date thereof 8-7-39 (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson Shereveport La

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2821 Stoddard St

19. (a) AUG 7 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2nd year 1939 hour 4:05 minute A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion (Thrombosis); Chronic Interstitial Nephritis;

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Joseph M. Queen (M. D. or other)

Address Deputy Coroner Date signed 8/4

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

X19311

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 Myself Lonnie Boykins, Registered Apprentice No. ..... working under my personal supervision.

Signed Lonnie Boykin

Licensed Embalmer No. 2946

P. O. Address St Louis 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 this body is not embalmed, above space should be left blank.