

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

OCT 20 1929

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

32595  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson 3 Registration District No. 400  
 (b) Township Prune 1 Primary Registration District No. 5553B Registered No. 186  
 (c) City Blue Bluff (d) Street No. Jackson County Home for the aged & infirm  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 5 5 2 Sarah CUNNINGHAM  
 2. PRINT FULL NAME  
 (a) Residence, No. J.C. Home St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan-10-1862

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>77</u>	<u>8</u>	<u>4</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Ernest Jackson  
J.C. Home

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park, R.C. Co. DATE Sept 18 1929

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kettledin  
R.emo.

20. FILED 9/18/1929 Card S. Barnes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 14 1929

22. I HEREBY CERTIFY, That I attended deceased from 8-1-1929 to 9-14-1929  
 I last saw her alive on 9/12/29. Death is said to have occurred on the date stated above, at H.A. m.  
 The principal cause of death and related causes of importance were as follows:  
chronic myocarditis Date of onset

Other contributory causes of importance: 930

Name of operation clinical Date of no

What test confirmed diagnosis clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) J. W. Green, M. D.  
9322 (Address) St. Louis  
720

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**