

No. 2
11-10-39
5-17-40
1-2-41

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

16663
State File No. _____
Registrar's No. **4141**

Registration District No. **791**

Primary Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")
(d) Street No. 3817 1/2 Dunnick
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Harmon Cunningham
3. (b) If veteran. _____ 3. (c) Social Security No. _____
name war _____ No. _____

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 16, 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation none - ten years

11. Industry or business farmer

12. Name Unknown

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name Unknown

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant J. W. Cunningham

(b) Address 3817 1/2 Dunnick

17. (a) Cremation (b) Date thereof 5-9-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Southern Funeral

(b) Address 6322 S. Grand

19. (a) MAY 8 1940 (b) _____ (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7th
year 1940 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture of left femur, arteriosclerosis, bronchopneumonia, suffered in fall to floor at City Hospital, St. Louis, Mo. April 21, 1940
Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy _____

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

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

(b) Date of occurrence Apr. 20 1940

(c) Where did injury occur? St. Louis Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 12 Public Place
(Specify type of place) (e) Means of injury Fall

23. Signature Joseph M. Anderson (Dr. or other)

Address Deputy Coroner Date April

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Frank Ludwig

Licensed Embalmer No.

2504

P. O. Address

St Louis W

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.