

Registration District No. 399

Primary Registration District No. 1002

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Vinyard Park Hospital 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 1/2 hours  
(Specify whether Life)  
 In this community Life  
years, months or days

3. (a) PRINT FULL NAME Anna Mae Cunningham 552  
 (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. 496-01-6370

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: January 27, 1920  
(Month) (Day) (Year)

8. AGE: Years 20 Months 6 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Joseph, Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Artist

11. Industry or business Retail Card & Stationery  
 MOTHER FATHER { 12. Name Frank R. Cunningham  
 13. Birthplace Kansas City, Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Estella Piepmeyer  
 15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank R. Cunningham, father  
 (b) Address 3224 Wabash, K. C. Mo.

17. (a) Burial (b) Date thereof 8/16/40.  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Melody-McGilley  
 (b) Address K. C. Mo.

19. (a) Aug. 15, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3224 Wabash Avenue  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month August day 14 th  
 year 1940 hour 7:00 minute AM M.  
 21. I hereby certify that I am a Physician who has seen the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
 Immediate cause of death: \_\_\_\_\_  
 Duration \_\_\_\_\_

Acute pulmonary edema  
Acute streptococcal septicemia  
(cause not yet determined)  
 Other conditions 140  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, from the following:  
 (a) Accident, suicide, or homicide \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where occurred \_\_\_\_\_  
(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 \_\_\_\_\_  
 23. Signature Melody McGilley (M. D. or other) \_\_\_\_\_  
 Address K.C. Mo. Date signed \_\_\_\_\_

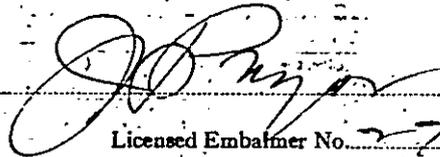
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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. 2799

P. O. Address .....

**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:**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27588  
Registrar's No. 3222

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(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

8. (a) PRINT FULL NAME: ANNA MAY CUNNINGHAM

3. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 9/27/40 (b) M. M. Brown (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street, No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day 8.14.40 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that \_\_\_\_\_ the deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_; the deputy coroner 7:30 P.M. death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Acute streptococcus septuemia  
Septic incomplete abortion  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions N.M.O.  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(or) Month of injury \_\_\_\_\_

23. Signature Walter H. Nelson (M. D. or other) 8/22/40  
Address H. C. Co. Date signed \_\_\_\_\_

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

5-27588

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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 comply with the above constitutes grounds for revocation of license.)**

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