

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8133**
Registrar's No. **360**

Registration District No. **284**

Primary Registration District No. **200**

1. PLACE OF DEATH: **ST. LOUIS**
(a) County **ST. LOUIS**
(b) City or town **ROCK**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ROBERT ROCK HOSPITAL A**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **131 days**
(Specify whether In this community years, months or days)

3. (a) PRINT FULLNAME **CORINNE CUNNINGHAM**
3. (b) If veteran, name war **NO**
3. (c) Social Security No.

4. Sex **FEMALE**
5. Color or race **NEGRO**
6. (a) Single, widowed, married, divorced **SINGLE**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **29** years (Day) (Year)
7. Birth date of deceased **10 - 29 - 1922**
(Month) (Day) (Year)

8. AGE: Years **18** Months **3** Days **20**
If less than one day hr. min.

9. Birthplace **ST. LOUIS** **U. S. A.**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business

MOTHER FATHER { 12. Name **RUBEN CUNNINGHAM**
13. Birthplace **MILAN** **TENN.**
(City, town, or county) (State or foreign country)
14. Maiden name **LUCY ROEBUCK**
15. Birthplace **TENN.**
(City, town, or county) (State or foreign country)

16. (a) Informant **PATIENT**

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof **2-17-41**
(Month) (Day) (Year)

(c) Place: burial or cremation **City Burial**

18. (a) Signature of funeral director **City of St. Louis**

(b) Address **Rock Rock (Ch. K. White)**

19. (a) **FEB 17 1941** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **MO**
(c) City or town **ST. LOUIS** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **2637 SPRUCE STREET** **19**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **LIFE!** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **FEB** day **13**
year **1941** hour **6** minute **05** P.M.
21. I hereby certify that I attended the deceased from **OCT**
2, 1940, to **FEB. 13**, 1941;
that I last saw alive on **FEB. 13**, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death
Parotitis
Preliminary Tuberculosis
Due to **13 10**
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy **Preliminary Tuberculosis**
Parotitis - the - det. find the

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) (b) Means of injury

23. Signature **[Signature]** (M. D. or other) **17/3/41**
Address **Rock, MO** Date signed

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.