

No. 2  
1-4-41  
17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11080

APR 10 1941

Registration District No. 425

Primary Registration District No. 5580

Registrar's No. 14-76

1. PLACE OF DEATH:

(a) County Person

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

(c) Name of hospital or institution:  
St. Joseph Hills Infirmay.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day  
(Specify whether years, months or days)

In this community 9  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Riverview Gardens  
(If outside city or town limits, write "RURAL")

(d) Street No. 10031 Sterling Drive.  
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)  
If yes, name country /

3. (a) PRINT FULL NAME Dennis Cunningham.

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 491-14-5411

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29th. year 1941 hour 9:00 minute A.M.

21. I hereby certify that I attended the deceased from December 39 to March 28 1941  
that I last saw h. l. m. alive on March 28 1941  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Julia Cunningham.

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

7. Birth date of deceased Sept 1900  
(Month) (Day) (Year)

Immediate cause of death Cardio, renal vascular disease Duration 1 yr

Due to \_\_\_\_\_

Due to \_\_\_\_\_

8. AGE: Years 66 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance.

Other conditions Cerebral arterio sclerosis  
(include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER { 12. Name James Cunningham.

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

14. Maiden name Margaret Fitzgerald.

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

16. (a) Informant Raymond Cunningham.

(b) Address 10031 Sterling Drive.

17. (a) Burial (b) Date thereof 4-1-41.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. 299 Mac 1941 (b) James A. Towne  
(Date received local registry) (Registrar's signature)

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 W.P. Hamilton (M. D. or other) MD

Address 8363 Hulls Ferry Date signed WRK

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

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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.....

*W Van Matre*

Licensed Embalmer No.....

*2825*

P. O. Address.....

*4340 Lafayette*

**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, fact should be so stated above.**