DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5680

Registration District No. 10 — Primary Registration District No. 3002 — Registrar's No. 17

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

1. PLACE OF DEATH:

(a) County: Audrain
(b) City or town: Mexico (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: None (Specify whether
In this community: 2 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Audrain 4
(c) City or town: Mexico (If outside city or town limits, write "RURAL") 1
(d) Street No.: 500 S. Western (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: William Henry Cundiff

3. (b) If veteran, name war: No — 3. (c) Social Security No.: No

4. Sex: M 0 — 5. Color or race: W — 6. (a) Single, widowed, married, divorced: 2 W

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

7. Birth date of deceased: Aug. 13, 1859 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
83	5	17	hr. min.

9. Birthplace: Calloway County, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER
12. Name: Wm. Cundiff
13. Birthplace: DK (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: Mayria Adkins
15. Birthplace: DK (City, town, or county) 9 (State or foreign country)

16. (a) Informant: Mrs. George Griffin
(b) Address: Mexico, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/8/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Johnson Cemetery

18. (a) Signature of funeral director: Chas Cundiff Jr
(b) Address: Mexico, Missouri

19. (a) Feb-2-1943 (Date received local registrar) (b) Margaret H Mackie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Jany day: 31st year: 1943 hour: 5 to 5 minute: 30 M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Viewed body and determined death was due to natural causes

Due to:

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
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? (Specify type of place)
While at work? (e) Means of injury: 2

23. Signature: Ed Shannon, Acting Coroner (M.D. or other)
Address: Mexico, Mo. Date signed: 2-2-43

1074 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 3-43-328
Date Filed FEB 15 1943

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 [illegible]

Licensed Embalmer No. 3569

P. O. Address [illegible]

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

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

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-21-41
X29288

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Registration District No. ..... Primary Registration District No. ..... Registrar's No. 17

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Mexico
(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 2 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Audrain

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

(d) Street No. 500 S. Western
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME William H Cundiff

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

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

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

7. Birth date of deceased Aug. 13 (Month) – 1859 (Day) (Year)

8. AGE: Years 83 Months 3 Days 17 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

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

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

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

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19 to ..... , 19 ..... that I last saw h ..... alive on ..... , 19 ..... and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Senility and exhaustion of old age. General	
Due to decline in health over period of years.	
Other conditions ..... (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

162 P

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)

(b) 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 E A Shannon Actg (M.D. or other)

Address Coroner, Audrain Co. Mo Date signed 3/28/43

SUPPLEMENTARY