

FILED JAN 11 1948 **STANDARD CERTIFICATE OF DEATH**

State File No.

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 270

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. State Hospital No. 4 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 yrs. 6 mos. 24 days.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 94
(c) City or town Maplewood
(If outside city or town limits, write "RURAL")
(d) Street No. Jerome Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HUGH MURPHY CUNNINGHAM

3. (b) If veteran, name war Unknown 3. (c) Social Security No. None

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

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

7. Birth date of deceased February 9, 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 10 6
hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name William Cunningham
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Fannie Geines
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 12-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem., Farmington, Mo.

18. (a) Signature of funeral director Miller Funeral Service Farmington, Missouri
(b) Address _____

19. (a) 12-28-45 (b) Ether Rudloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15
year 1945 hour 9 minute 40 A. M.

21. I hereby certify that I attended the deceased from May 21, 1927, 19____, to Dec. 15, 1945, 19____;
that I last saw him alive on Dec. 15, 1945, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Epilepsy Duration 20 yrs

Due to _____

Due to Mental deficiency
Other conditions Bird Paralysis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy No 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?
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Ames - Hoehn (M. D. or other)
Address Farmington Date signed 12/15/45

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

RECEIVED

District Health Officer No. 4
District File Number 146-1543
Date Filed 1-9-46

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~~.....

Not embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed Paul K. Shepal.....

Licensed Embalmer No. 4120.....

P. O. Address Farmington Mo......

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.