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DEPARTMENT OF COMMERCE
Bureau of Vital Statistics
FILED JUN 18 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19680

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1172

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 5/9/47
(Specify whether
In this community 7 years
years, months or days)

3. (a) PRINT FULL NAME CUNNAGAN, Willie

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

4. Sex male 2 5. Color or race negro 6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife 46 Cornelius Cunnagan 6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased May 9, 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 | 0 | 27 | 5 hr. 25 min.

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

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name John Cunnagan
13. Birthplace unknown /
(City, town, or county) (State or foreign country)
14. Maiden name Carrie Fields
15. Birthplace Vicksburg, Mississippi /
(City, town, or county) (State or foreign country)

16. (a) Informant Registrar, Vet. Adm. Hospital
(b) Address Jefferson Barracks 23, Missouri
17. (a) burial (b) Date thereof 6-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jefferson Brks Natl
18. (a) Signature of funeral director James H. Randle and Son
(b) Address 3133 Bell, St. Louis, Missouri

19. (a) 6-12-47 (b) W. E. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 907 1/2 N. Compton
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
year 1947 hour 5:25 minute _____ AM.

21. I hereby certify that I attended the deceased from May 9, 1947, 19____ to June 6, 1947
that I last saw him alive on June 6, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
PNEUMONIA, LOBAR, LEFT, UPPER LOBE
2. ABSCESS, LEFT LUNG, UPPER LOBE
Due to 3. HEMIPLEGIA, RIGHT
4. APHASIA

Duration

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

Major findings:
Of operations No operation

PHYSICIAN

Of autopsy Autopsy performed (See Cause of Death)

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) no
(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)
(c) Means of injury 0

23. Signature L. E. Schwel (M. D. or other) _____
Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 6/6/47

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: *S. J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *2769 Houston*

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.