

No. 2  
-12-45  
-17-39  
X47970

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED AUG 21 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. 22260  
Registrar's No. 2-15

Registration District No. 107

Primary Registration District No. 5428

**1. PLACE OF DEATH:**

(a) County Dunklin

(b) City or town Kennett Rural, Ind. Dep.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
(years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Dunklin

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

3. (a) Robert Allen Cunningham

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

3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 8 day 16  
year 1947 hour 2:00 minute a M.

21. I hereby certify that I attended the deceased from August 13, 1947 to August 15, 1947  
that I last saw her alive on August 15, 1947  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 8-13-1947  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>2</u>	<u>3</u>	_____ hr. _____ min.

Immediate cause of death Bronchial Pneumonia Duration 1 1/2 days

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name F. B. Cunningham

13. Birthplace Clay Co. Ark  
(City, town, or county) (State or foreign country)

14. Maiden name Rose Barker

15. Birthplace Clay Co. Ark  
(City, town, or county) (State or foreign country)

16. (a) Informant F. B. Cunningham

(b) Address Kennett R. # 3

17. (a) Burial (b) Date thereof 8-16-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Hill Cem

18. (a) Signature of funeral director F. B. Farnsworth

(b) Address Kennett Mo

19. (a) 8-16-1947 (b) Carl Hubbard  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

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 L

23. Signature F. B. Farnsworth (or other) Dr.

Address Briggsville Mo Date signed 8-16-47

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

RECEIVED

District Health Office No.

District File Number 847-11

Date Filed 8-18-47

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**