

S. No. 2
OM-5-43
Rev. 5-17-39
I X36671

FILED OCT 24 1947 318

State File No. _____
Registrar's No. 9316

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
The City Infirmary Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution August 19, 47
(Specify whether
In this community To Oct. 5, 1947
years, months or days)

3. (a) PRINT FULL NAME Cunningham, Joe

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

4. Sex Male 2 5. Color or race Col.

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

6. (b) Name of husband or wife Mattie

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased August 15, 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>1</u>	<u>20</u>	hr. _____ min.

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

10. Usual occupation Laundry worker

11. Industry or business _____

12. Name Edmond Cunningham

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

14. Maiden name Ollie ?

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

16. (a) Informant City Infirmary Records

(b) Address 5800 Arsenal Street

17. (a) Burial (b) Date thereof 10/10/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) OCT 8 1947 (b) J. F. Braddock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ood

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3326 Franklin Avenue 7
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5,
year 1947 hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from August 19, 1947, 19 _____ to October 5, 1947, 19 _____ that I last saw him alive on October 5, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure
= pulmonary congestion

Due to senility

Due to _____

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

Major findings:
Of operations _____

Of autopsy Same

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? _____

23. Signature Warren C. Lewis (M. D. or other) _____
Address 602 Arsenal Date signed 10-6-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

.....Thomas J. Gates....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Thomas J. Gates

Licensed Embalmer No. 4259

P. O. Address. 407 7

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.