

S. No. 304  
M-10-47  
7. 5-17-39  
I 3908

#54731  
FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **2407**  
Registrar's No. **918**

FILED FEB 9 1948 **318**  
Registration District No.

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital—Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 1/2 Months  
In this community 4 1/2 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4014a Cleveland Avenue  
Memorial (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN CUNNINGHAM  
3. (b) If veteran, name war Nil  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 28th  
year 1948 hour 7 minute 30 P M.  
21. I hereby certify that I attended the deceased from 10/22/47  
\_\_\_\_\_, 19\_\_\_\_, to Jan 28th, 1948.  
that I last saw him in alive on Jan 28th, 1948,  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced W 2  
6. (b) Name of husband or wife Mary L. alive \_\_\_\_\_ years  
6. (c) Age of husband or wife if \_\_\_\_\_ years

Immediate cause of death Thrombosis of the mesenteric  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 77 Months 0 Days 6  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions Occlusion of rt. popliteal artery  
(Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Boydsville, Kentucky  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer  
11. Industry or business Retired

MOTHER FATHER { 12. Name Joe Cunningham  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant E. J. Cunningham  
(b) Address 4014a Cleveland Avenue  
17. (a) Removal (b) Date thereof 1-29-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Fulton, Kentucky

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 J. F. Brudeck (City, town, or county) \_\_\_\_\_  
Address 1515 Lafayette \_\_\_\_\_ Date signed \_\_\_\_\_

18. (a) Signature of funeral director A. W. McLaughlin  
(b) Address 2301 Lafayette Avenue  
19. (a) JAN 29 1948 (b) J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

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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..... *L R Cooper* .....

Licensed Embalmer No. *3633* .....

P. O. Address. *2361 Lafayette* .....

**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.**