

No. 300
-10-47
S-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26231**
Registrar's No. **3380**

FILED SEP 4 1948
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **JACKSON**
(b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
626 WEST 14th STREET
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **20 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **626 WEST 14th STREET**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **RUTH E. CUNNINGHAM**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **DIVORCED**
6. (b) Name of husband or wife **HARRY CUNNINGHAM**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JANUARY 26 1896**
(Month) (Day) (Year)

8. AGE: Years **52** Months **6** Days **22**
If less than one day _____ hr. _____ min.

9. Birthplace **JAMESVILLE MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____

MOTHER FATHER
12. Name **ROBERT OWENS**
13. Birthplace **UNKNOWN**
(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 **MISS WINIFRED W. CUNNINGHAM**
(b) Address **626 WEST 14th STREET**

17. (a) **BURIAL** (b) Date thereof **8-20-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **MT. ST. MARY'S CEMETERY**

18. (a) Signature of funeral director **J. F. G. [Signature]**
(b) Address **3256 ROCKWAY**

19. (a) **8-19-48** (b) **Seraldine Holme**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **18** -
year **1948** hour **12:15** P.M.

21. I hereby certify that I attended the deceased from **July 20** to **Aug 18**, 19**48**
that I last saw her alive on **Aug 18**, 19**48** and that death occurred on the date and hour stated above.

Immediate cause of death:
Hypertension cerebral hemorrhage Chr. Myocarditis. Colitis.
Due to _____
Due to _____
Other conditions **no**
(Include pregnancy within 3 months of death)

Duration
5 yrs
5 yrs
5 yrs
5 yrs

Major findings:
Of operations **no 93d**
Of autopsy **no**

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 **MP. Chubbell** (M.D. or other) _____
Address **4000 Baltimore** _____

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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address K. C. 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.