No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42134

BIRTH NO. _____ REG. DIST. NO. 518 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11194

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2755 St Vincent

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS 2239
d. STREET ADDRESS (If rural, give location): 2755 St. VINCENT AV

3. NAME OF DECEASED (Type or Print)
a. (First): NONIE
b. (Middle):
c. (Last): CUNNIFF.

4. DATE OF DEATH (Month) (Day) (Year): DEC ~~29~~ -1950

5. SEX: FE.
6. COLOR OR RACE: W
7. ~~MARRIED~~, NEVER MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): SINGLE
8. DATE OF BIRTH: JAN-1-1885
9. AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): IRELAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: MALACHY CUNNIFF.
13b. MOTHER'S MAIDEN NAME: MARY GRIFFIN
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs Mary O'Keefe

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 331 X

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 0454 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Patrick E Taylor's Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 12 29 50

24a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): BURIAL
24b. DATE: DEC.-30-50
24c. NAME OF CEMETERY OR CREMATORY: CALVARY Cem.
24d. LOCATION (City, town, or county) (State): St Louis Mo.

DATE REC'D BY LOCAL REG.: DEC 29 1950
REGISTRAR'S SIGNATURE: J. B. Lobster
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: E. J. Schnur 3125 Lafayette av

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Jos B. Vollmer

Signed.....
Student Embalmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.