

FILED APR 27 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13945  
State File No. 3526

BIRTH NO. 24264-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1 day 12 hrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2069	
3. NAME OF DECEASED a. (First) Jacqueline		b. (Middle) Elaine	
c. (Last) Cunningham		4. DATE OF DEATH (Month) (Day) (Year) 4 5 51	
5. SEX Fem. 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 4-4-51
9. AGE (In years last birthday) 1 12		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME William Cunningham		13b. MOTHER'S MAIDEN NAME Corrine Henrietta Hudspeth	
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 M. M. Sherrard, ARL2601 N. Whittier	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 776X		22. I hereby certify that I attended the deceased from 4-4-1951, to 4-5-1951, that I last saw the deceased alive on 4-5-1951, and that death occurred at 6:00p.m., from the causes and on the date stated above.	
23a. SIGNATURE W. W. Nicholls 0		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 4-11-51		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 5 APR 16 1951		24c. NAME OF CEMETERY OR CREMATORY Anatomical Bourne	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	
DATE REC'D BY LOCAL REG. APR 16 1951		REGISTRAR'S SIGNATURE J. B. Linsler	

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

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.