

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17965

State File No.

FILED JUN 15 1951

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REG. DIST. NO. PRIMARY REG. DIST. NO. 1003 Registrar's No. 5089

WRITE PLAINLY—USING UNFAADING 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 Illinois b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) 29 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 215 West Harrison Street	
3. NAME OF DECEASED (Type or Print) a. (First) Helen b. (Middle) Rita c. (Last) Cunningham			4. DATE OF DEATH (Month) (Day) (Year) June 1, 1951
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 2 1910
9. AGE (In years last birthday) 41		10. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) El Paso, Illinois
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Patrick Clarry		13b. MOTHER'S MAIDEN NAME Eva Greenwald	14. NAME OF HUSBAND OR WIFE William Cunningham
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Cunningham-Decatur, Ill.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Reticulum cell sarcoma with metastases ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Terminal bronchopneumonia and pyelonephritis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2000	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
22. I hereby certify that I attended the deceased from May 3, 1951, to June 1, 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 8:50 P. M., from the causes and on the date stated above.			
23a. SIGNATURE F. R. Bradley (Degree or title) M.D.		23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 6/1/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-2-51	24c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	24d. LOCATION (City, town, or county) (State) Bloomington, Illinois
DATE RECD BY LOCAL REG. 2-5-51	REGISTRAR'S SIGNATURE J. B. Faunter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe-4700 Washington Blvd	

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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 _____

working under my personal supervision.

Student Embalmer No.

Signed

John J. Harris

Signed.....

Student Embalmer

Licensed Embalmer No. *4108*

P. O. Address *St Louis 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.