

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **35410**

FILED NOV 16 1956

REG. DIST. NO. **318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **9721**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>9721</b>			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY OR TOWN <b>St. Louis, Mo</b>		c. LENGTH OF STAY (In this place) <b>Over 1 year</b>		3. CITY OR TOWN <b>St. Louis, Mo.</b>		d. STREET ADDRESS (If rural, give location) <b>5357 Delmar</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Masonic Home of Missouri</b>				Masonic Home of Mo.					
3. NAME OF DECEASED (Type or Print) <b>SAM (NME) CUNNINGHAM</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 23 1956</b>						
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>		8. DATE OF BIRTH <b>MARCH 21 1886</b>			
9. AGE (In years last birthday) <b>80</b>		10. MONTHS <b>7</b>		11. DAYS <b>2</b>		12. IF UNDER 14 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Credit man</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>Brooklyn, NY</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13a. FATHER'S NAME <b>Thomas Cunningham</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT'S SIGNATURE OR NAME <b>James Robertson</b>		ADDRESS <b>Masonic Home of Missouri</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Atherosclerosis 20 yrs.</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 <b>331x</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?					
22. I hereby certify that I attended the deceased from <b>7-25, 1955, to 10-23, 1956</b> , that I last saw the deceased alive on <b>10-23, 1956</b> , and that death occurred at <b>11:20 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Harold E. Walters M.D.</b>				23b. ADDRESS <b>3120 Washington St. Louis, Mo.</b>				23c. DATE SIGNED <b>10-24-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Oct. 26, 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>OCT 24 1956</b>		REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander &amp; Sons, Inc.</b>		ADDRESS <b>6175 Delmar</b>			

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

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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 *Jose E. McCulloch*

Licensed Embalmer No. *2460*

P. O. Address *6175 Dellman*

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.