

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 18 1957

Registration District No. 318

318

Primary Registration District No. 1003

1003

STATE FILE NUMBER 10122  
1810  
Registrar's No.

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Brothers Hospital</b>				Length of stay in days <b>2 1/2</b>		STREET ADDRESS (If outside, give location) <b>3535 Utah St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>J.</b> Last <b>Cunningham</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>20.</b> Year <b>1957</b>			
5. SEX <b>Male</b> <input type="checkbox"/> <b>Female</b> <input checked="" type="checkbox"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18, 1882</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (City and state or country) <b>Alton, Illinois, /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Cunningham</b>				14. MOTHER'S MAIDEN NAME <b>Mary OBen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Nil.</b>		17. INFORMANT Address <b>C. W. Connors, St. Louis, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Several weeks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420-0</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>		COUNTY STATE	
21. I attended the deceased from <b>2/19/57</b> to <b>2/20/57</b> and last saw <sup>her</sup> <del>him</del> alive on <b>2/19/57</b> Death occurred at <b>8 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>J. A. Mezera M.D.</b>				22b. ADDRESS <b>8059 Watson Rd.</b>		22c. DATE SIGNED <b>2/23/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-21-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemtery</b>		23d. LOCATION (City, town, or county) (State) <b>Godfrey, Illinois,</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Staten Funeral Home, Alton, Illinois,</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 23 57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>S.P.</b>	

(Licensed Embalmer's Statement on Reverse Side)

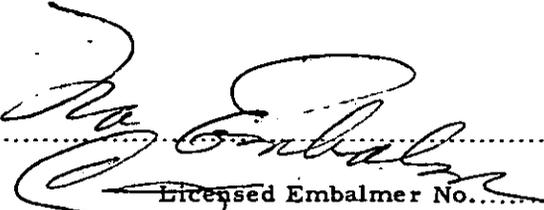
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

X St. Louis, Mo. X St. Louis, Mo.  
 X 3232 Utah St. Alexandria, Va.  
 Feb. 20, 1927 Birmingham, Ala. J. Charles  
 1885 Jan. 10, 1885 White  
 Alton, Illinois Hotel Auditor  
 Mary Owen Frank  
 St. Louis, Mo. Unknown M. J. M.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb  
 by me, or by ..... Student Embalmer No.....  
 working under my personal supervision..

Student.....  
 Signature of Student Embalmer

Signed.....  
  
 Licensed Embalmer No.....  
 P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
 to comply with the above constitutes grounds for revocation of license).  
 If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
 If this body is not embalmed, fact should be so stated above.

St. Louis, Mo. Alton, Ill.