

Health,
& Welfare
Public
Service

Cunningham

FILED MAY 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16700
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 479

S. 300
1-57
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1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY Greene (mission) <input checked="" type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield 0396	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital	Length of stay in 1b 33 Yrs.	d. STREET ADDRESS (If outside, give location) 2435 W. Calhoun	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LUCY Middle A. Last BERRY			4. DATE OF DEATH Month May Day 17 Year 1957			
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Dec. 1878	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE W.P. Berry
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Hospital Records	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) Coronary Thrombosis DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201		

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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	COUNTY	STATE
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21. I attended the deceased from Nov. 1956 to May, 1957 and last saw ^{her} alive on May 17, 1957 Death occurred at 7:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>D. Dean Cunningham, M.D.</i>	(Degree or title) O	22b. ADDRESS Spigd. Med. Bldg. Springfield, Missouri	22c. DATE SIGNED 5-19-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-20-57	23c. NAME OF CEMETERY OR CREMATORY White Chapel	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
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24. FUNERAL DIRECTOR <i>J.W. Keigler & Co.</i>	ADDRESS Spigd. Mo.	25. DATE RECD. BY LOCAL REG. 5-20-57	26. REGISTRAR'S SIGNATURE <i>Edith Williams</i>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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
Signature of Student Embalmer

Signed *Mal Rhode*

Licensed Embalmer No. *407*
P. O. Address *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.