

hh,  
ffare  
lic  
vice

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 15 1957

57 07 16 44  
STATE FILE NUMBER

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 81

1. PLACE OF DEATH a. COUNTY <b>Johnson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Warrensburg</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Centerview</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Warrensburg Med.Cen. 3 Days</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>RFD 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>James</b> Last <b>Cunningham</b>			4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1878</b>		9. AGE (In years last birthday) <b>78</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grain &amp; Stock</b>	11. BIRTHPLACE (City and state or country) <b>Bell Vernon, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Albert G. Cunningham</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Rankin</b>		14. NAME OF HUSBAND OR WIFE <b>Effie A. Cunningham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, pp. or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-42-8969</b>		17. INFORMANT Address <b>Mrs. W. J. Cunningham, RFD 2, Centerview</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>Thrombosed Carotid Arteries</b>					INTERVAL BETWEEN ONSET AND DEATH <b>17 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b>					<b>2 months</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>153x</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 Month, Day, Year 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	
21. I attended the deceased from <b>June 17, 57</b> to <b>July 10, 57</b> and last saw <sup>her</sup> <b>him</b> alive on <b>July 10, 57</b> Death occurred at <b>7 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>W. J. Cunningham</i> (Degree or title) <b>M.D.</b>			22b. ADDRESS <b>Warrensburg, Mo</b>		22c. DATE SIGNED <b>July 11, 57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>13 July 57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Centerview</b>		23d. LOCATION (City, town, or county) (State) <b>Centerview, Missouri</b>
24. FUNERAL DIRECTOR <b>Sweeney-Phillips, Warrensburg, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>July 12, 1957</b>		26. REGISTRAR'S SIGNATURE <i>Savannah Cutchfield</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Earl Priest* .....

Licensed Embalmer No. *3878* .....

P. O. Address *Warrensburg* .....

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.