

Health,
& Welfare
Public
Service

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35750

STATE FILE NUMBER

4807

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

S. 300
1-57

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
Chas. G. Stepiens
Removal

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN 479 Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lakeside Hospital		Length of stay in lb 30 yrs	
d. STREET ADDRESS 3128 Central		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BEULAH MARIE CUNINGHAM			4. DATE OF DEATH Month Day Year Oct. 17, 1957
5. SEX Female	6. COLOR OR RACE White Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1899
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Kennett Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY At home	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William A. Spencer		13b. MOTHER'S MAIDEN NAME Sarah Belle Frankum	14. NAME OF HUSBAND OR WIFE John H. Cuningham
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. 486-07-2225	17. INFORMANT Address John H. Cuningham - 3128 Central - K.C., Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Creamia DUE TO (c) Influenza			INTERVAL BETWEEN ONSET AND DEATH 3 days 2 weeks 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4807			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. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 July 12, 1957 to Oct 17, 57 and last saw her alive on Oct 16, 1957 Death occurred at 5:15am on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) Chas. G. Stepiens		22b. ADDRESS 3-E-39th St. Kansas City, Mo	22c. DATE SIGNED 10-18-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial &		23b. DATE 10-19-57	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
24. FUNERAL DIRECTOR Melody-McGilley-Eylar		25. DATE RECD. BY LOCAL REG. 10-18-57	26. REGISTRAR'S SIGNATURE Neva Minshall
ADDRESS Kansas City, Mo.			

D. Charles K. Steg
Merley Bldg.
39th & Main
WE 1-4415

1:00 PM

AP
2

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 *James W. Wair*

Licensed Embalmer No. *4650*
P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. -
If this body is not embalmed, fact should be so stated above.