

Health, Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000186

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sedalia</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Hospital</u>			Length of stay in 1b <u>40 days</u>		d. STREET ADDRESS (If outside, give location) <u>Route 5</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Jobe</u> Last <u>Cunningham</u>				4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-18-1891</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>COOPER COUNTY, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ANDREW JACKSON JOBE</u>			13b. MOTHER'S MAIDEN NAME <u>MARGARET E. RHOADS</u>			14. NAME OF HUSBAND OR WIFE <u>Wm. CUNNINGHAM</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>HOSPITAL CHART</u>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CIRRHOSIS OF LIVER</u>		DUE TO (c)		Interval <u>Some one year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>STAPHYLOCOCCUS SEPTICEMIA ; CANCER OF CERVIX</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>1:02</u> Month <u>11</u> Day <u>58</u> Year <u>58</u> 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		COUNTY		STATE
21. I attended the deceased from <u>12-11-58</u> to <u>2-4-59</u> and last saw her <sup>him</sup> alive on <u>2-4-59</u> Death occurred at <u>1:02 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Stane Burkhardt, M.D.</u> (Degree or title)				22b. ADDRESS <u>4. of 9th Medical Center, Columbia</u>			22c. DATE SIGNED <u>2-4-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Feb 4 1959</u>	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>		
24. FUNERAL DIRECTOR <u>Billiepie Funeral Home</u>				ADDRESS <u>Sedalia Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 4 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 20 1959

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 .....

Licensed Embalmer No.....

P. O. Address .....

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.