FILED SEP 16 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

28168
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau   Registration District No. 125

(b) Township Cape Girardeau   Primary Registration District No. 3009   Registered No. 278

or (c) City Cape Girardeau   (d) Street No. St. Francis Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred   yrs.   mos.   ds.   (f) How long in U. S., if of foreign birth?   yrs.   mos.   ds.

55 7

2. PRINT FULL NAME Fannie A. Cunningham

(a) Residence, No. Cape Girardeau County St.
(Usual place of abode, if no street address, write county or city)   (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. H. L. Cunningham

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 12 - 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	72	11	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)   11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Charleston Missouri

FATHER

13. NAME S. S. Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Elizabethtown Kentucky

MOTHER

15. MAIDEN NAME Virginia Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jefferson County Missouri

17. INFORMANT Dr. H. L. Cunningham
(ADDRESS) Cape Girardeau Mo.

18. BURIAL, CREMATION, OR REMOVAL Memorial Park
PLACE Cape Girardeau Co. DATE Aug 22 1940

19. FUNERAL DIRECTOR (NAME) Walther's And Co.
(ADDRESS) Cape Girardeau Mo.

20. FILED 8-21 1940 J. M. Thompson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 21 1940

22. I HEREBY CERTIFY, That I attended deceased from Aug 1 1940, to Aug 21 1940

I last saw her alive on Aug 20 1940 Death is said to have occurred on the date stated above, at 12 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Gangrene of the Gallbladder	Aug 5 1940

Other contributory causes of importance:

Secondary Hemorrhage from G.B. area following cholecystectomy	8/20/40

Name of operation Cholecystectomy   Date of 8/8/40

What test confirmed diagnosis? Operation   Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ...... Date of injury ......, 19....

Where did injury occur? ......
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) George H. Walker M. D.

(Address) Cape Girardeau Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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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 ...., Registered Apprentice No. .... working under my personal supervision.

Signed J. H. [signature]

Licensed Embalmer No. 3982

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22639

ROWENA MOORE

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28168X

Registration District No. 125 — Primary Registration District No. 3009 — Registrar's No.

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Jo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Fannie A. Cunningham
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 72 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Gangrene of the gall bladder — Duration 4 days
Due to Cholelithiasis
Due to
Other conditions (Include pregnancy within 3 months of death) Secondary Hemorrhage from G. I. Following Cholecystectomy
Major finding at Operation
Of autopsy Gangrene of Gallbladder

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature George D Baker (M. D. or other)
Address Cape Girardeau Mo. Date signed 8-23-40

SUPPLEMENTARY