

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0032588

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7970**

FILED AUG 31 1967

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		St. Louis		8 yrs.		c. CITY OR TOWN		St. Louis		Inside Limits		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				6822 Pla teau		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				6822 Plateau		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)						First Middle Last			4. DATE OF DEATH								
BLANCHE						V. CUNNINGHAM			August 24, 1967								
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR					
Female		White				8-14-1889		78		Months Days		Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY							
housewife				Home		Ostrander, Ohio				U.S.A.							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE									
James Schoppert				Delia Jean Gates				Samuel T. Cunningham									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address											
No						Samuel T. Cunningham - 6822 Plateau											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a)												10 yrs.					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												4200					
DUE TO (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)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
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.)									
								None									
20c. TIME OF INJURY		Hour s.m. p.m.		Month, Day, Year				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 Aug 14 1967 to Aug 24 67 and last saw her alive on Aug 24 1967																	
Death occurred at 8:15 AM m on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED								
[Signature]						2648 Oakview Terr.			8-25-67								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)									
Removal		8-24-67		Mt. Hope Cemetery				St. Louis County, Mo.									
24. FUNERAL DIRECTOR ADDRESS						25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE									
JAY B. SMITH FUNERAL HOME - Maplewood, Mo						AUG 25 1967		[Signature]									

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 *J. H. Burgess*

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.