

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

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8939**
Registrar's No. **2422**

Registration District No. **761** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution (If outside city or town limits, write "RURAL" and name of township)
3875a Washington Ave ✓
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME James C. Funkhouser

8. (b) If veteran, name war No 8. (c) Social Security No. None

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

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

7. Birth date of deceased Nov. 16, 1856
(Month) (Day) (Year)

8. AGE: Years 83 Months 3 Days 25 If less than one day hr. min.

9. Birthplace Mockport, Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer
11. Industry or business Retired

12. Name Phillip Funkhouser
13. Birthplace W. Virginia
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Lee J. Funkhouser
(b) Address 2525a N. Prairie

17. (a) Removal (b) Date thereof 3/14/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oran, Missouri

18. (a) Signature of funeral director R. M. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) MAR 12 1940 (b) J. F. Budeth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")
(d) Street No. 3875a Washington Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
year 1940 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from March 8
1940, to March 11, 1940
that I last saw him alive on March 11, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Acute dilatation of heart
Duration 2 yrs. 1 day

Due to Upper respiratory infection (Bronchitis) 1 mos

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations none
Of autopsy none
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature James D. Katz M.D. (M. D. or other) 1
Address 3903 Olive St Date signed 3/12/40

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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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