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12-43  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39870

FILED DEC 29 1943  
Registration District No. 500

Primary Registration District No. 6225

State File No. \_\_\_\_\_

Registrar's No. 159

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Sumner, Nevada  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hosp. No. 3  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr. 11 mo 9 da  
(Specify whether years, months or days)

In this community Same time

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell

(c) City or town West Plains  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Portia Funkhouser

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

4. Sex F

5. Color or race W.

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife C. F. Funkhouser

6. (c) Age of husband or wife if alive Dead years \_\_\_\_\_

7. Birth date of deceased Feb 2 - 1874  
(Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 7  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Fairfield Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business own home

12. Name John W. Davis

13. Birthplace Ills.  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Byers

15. Birthplace Ills.  
(City, town, or county) (State or foreign country)

16. (a) Informant  Hosp. Records

(b) Address Nevada mo

17. (a) Bury (b) Date thereof 11-11-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Plains mo

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Nevada mo

19. (a) 11-9-43 (b) Rayl B. Bewick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9th  
year 1943 hour 5:15 A minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb. 1 - 1943  
to Nov. 9 1943  
that I last saw her alive on Nov 8 - 1943 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Psychosis with Cerebral Arteriosclerosis

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Includes pregnancy within 5 months of death)

Major findings: 94

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

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)

(c) Means of injury MD

23. Signature RB Bates (M. D. or other) \_\_\_\_\_  
Address Nevada mo Date signed 11-9-43

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

MOTHER FATHER

1337

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Public Health

NOV 74

License No. Number

11-43-1299

Date

12-6-43

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 ME

Registered Apprentice No. ....

working under my personal supervision.

Signed

Mike E. Ferry

Licensed Embalmer No.

1432

P. O. Address

Nevada 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 this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec  
Registrar's No. 159

Registration District No. 360

Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Union  
(b) City or town Rural - Washington Twp  
(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  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Patricia Funkhouser

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 w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Feb 28 1943  
(Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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) Hazel B. Burch (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 1943 year \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-39370