

U. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 19 1945
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18721**
Registrar's No. **5099**

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

1. PLACE OF DEATH:
(a) County **ST. LOUIS**
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **4458 Clarence**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County **0001**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **4458 Clarence**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CIARA FUNKE**
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 **S**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **NOV 27 1889**
(Month) (Day) (Year)

8. AGE: Years **55** Months **6** Days **11** If less than one day _____ hr. _____ min.

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

10. Usual occupation **HOUSE WORK**

11. Industry or business **SELF**

12. Name **SIMON FUNKE**

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

14. Maiden name **DORTHEA HUGB**

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

16. (a) Informant **THEO. FUNKE**

(b) Address **4458 Clarence**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 11, 45**
(Month) (Day) (Year)

(c) Place: burial or cremation **NEW BETHELM**

18. (a) Signature of funeral director **Provoat and Co**

(b) Address **3748 N. Grand St**

19. (a) **JUN 9 1945** (Date received local registrar) (b) **J. Z. Bredek** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **8**
year **1945** hour **5** minute **15A** M.
21. I hereby certify that I attended the deceased from **June 5**, 19 **45** to **June 8**, 19 **45**
that I last saw **her** alive on **June 7**, 19 **45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pernicious Anemia**
Due to **Indef.**
Due to **Indef.**
Other conditions **gouty**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **None**
Of operations: _____
Of autopsy: _____
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 **2**
(c) Where did injury occur? **2**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **2**

While at work? _____ (Specify type of work) (e) Means of injury **0**
23. Signature **R. O. Riegler** (M. D. or other)
Address **415 8 Newstead** Date signed **6/8-45**

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

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17
9

MOTHER FATHER

*Right
Amended + Pee*

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 *Earl E Probst*

Licensed Embalmer No. *1578*

P. O. Address *3710 N. Grand Bl*

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.