

S. No. 2
-12-45
5-17-39
I X47070

FILED SEP 11 1947

Registration District No. **1178**

Primary Registration District No. **3026**

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution:
Independence Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 Days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **Jackson**

(c) City or town **Gilman City, Mo.**
(If outside city or town limits, write "RURAL")

(d) Street No. **Gilman City, Mo.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Mrs. Josie Funk**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

4. Sex **Fem** 5. Color or race **Wh**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ford Funk**

6. (c) Age of husband or wife if alive **54** years

7. Birth date of deceased **9/6/1893**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
53	II	II	hr. min.

9. Birthplace **Morgan Co., Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER

12. Name **James w. Maness**

13. Birthplace **Morgan Co., Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Lydia Steal**

15. Birthplace **Morgan Co., Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ford Funk**

(b) Address **Gilman City, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9/29/47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills Cemetery**

18. (a) Signature of funeral director **John B. Shell**

(b) Address **Kansas City, Mo.**

19. (a) **8-29-47** (Date received local registrar)

[Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **27th** year **1947** hour **8:55** minute **P** M.

21. I hereby certify that I attended the deceased from **Aug 19**, 1947, to **Aug 27th**, 1947
that I last saw h. **ER.** alive on **Aug 27th**, 1947
and that death occurred on the date at **8** hour stated above.

Immediate cause of death **Uremia** Duration **4 days**

Due to **Chronic nephritis & Anuria**
Hepato-Renal Syndrome **6 days**

Due to

Other conditions (Include pregnancy within 3 months of death)

12/13

Major findings: **Hydrops of Gall bladder**
Of operations: **with cholelithiasis**

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) (c) Means of injury **0**

23. Signature **Harold V Woods M.D.** (M.D. or other)

Address **Independence Mo** AUG 28 1947

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

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..... *John P. Scheil*
Licensed Embalmer No. *3625*
P. O. Address..... *Kansas City, 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.