

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6099

FILED MAR 2 1951

State File No. 1679
Registrar's No. 1003

BIRTH NO. 10039-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

I. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis Mo. c. LENGTH OF STAY (in this place township) 29 hrs 21 min
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL
e. STREET ADDRESS (If rural, give location) 20412 Madison

3. NAME OF DECEASED (Type or Print)
a. (First) GARY b. (Middle) CECIL c. (Last) FUNKHOUSER
4. DATE OF DEATH (Month) (Day) (Year) JAN. 28 - 1951

5. SEX MALE **6. COLOR OR RACE** WHITE **7. MARRIAGE HISTORY** ~~MARRIED~~ DIVORCED (Specify) INFANT **8. DATE OF BIRTH** JANUARY 27, 1951
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min. 29 | 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **10b. KIND OF BUSINESS OR INDUSTRY** **11. BIRTHPLACE** (State or foreign country) ST. Louis Mo. **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13a. FATHER'S NAME Allie Francis Funkhouser **13b. MOTHER'S MAIDEN NAME** Josephine Bernice **14. NAME OF HUSBAND OR WIFE**

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'S SIGNATURE OR NAME** Mrs. Josephine Funkhouser **ADDRESS** 22412 Madison

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Mal development. DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
INTERVAL BETWEEN ONSET AND DEATH 29 hrs 21 min

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY), (STATE)**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) **21e. INJURY OCCURRED WHILE AT WORK** NOT WHILE AT WORK **21f. HOW DID INJURY OCCUR?** 773.0

22. I hereby certify that I attended the deceased from January 27, 1951, to January 28, 1951, that I last saw the deceased alive on January 27, 1951, and that death occurred at 6:45 p.m. from the causes and on the date stated above.

23a. SIGNATURE Paul W. Parashak (Degree or title) **23b. ADDRESS** 5203 Chippewa **23c. DATE SIGNED** 9/31/51

24a. BURIAL, CREMATION, REMOVAL (Specify) **24b. DATE** FEB 20 1951 **24c. NAME OF FUNERAL HOME OR CEMETERY** Anatomical Board **24d. LOCATION** (City, town, or county) (State)

DATE RECD. BY LOCAL REG. FEB 20 1951 **REGISTRAR'S SIGNATURE** J. B. Hunter **25. FUNERAL DIRECTOR'S SIGNATURE** Anatomical Board **ADDRESS** 1402 S. Grand

WRITE PLAINLY—USING 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.....

....., Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.