

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31622**
4067

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City MO 23 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital		d. STREET ADDRESS (If rural, give location) 7203 Pennsylvania	

3. NAME OF DECEASED (Type or Print) a. (First) Mr Elmer b. (Middle) Ross c. (Last) Funk	4. DATE OF DEATH (Month) (Day) (Year) 9-12-1952
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5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1-20-1889	9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Shipping Clerk	10b. KIND OF BUSINESS OR INDUSTRY McPike Drugs	11. BIRTHPLACE (State or foreign country) Raymore MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Cyrus Markel Funk	13b. MOTHER'S MAIDEN NAME Clara May Kentigh	14. NAME OF HUSBAND OR WIFE Sarah May Funk
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 487-05-7587	17. INFORMANT'S SIGNATURE OR NAME Sarah May Funk	ADDRESS 7203 Penn.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 wks.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Increased intracerebral pressure		
ANTECEDENT CAUSES		DUE TO (b) Basilar meningitis and arachnoiditis 2 mo	
		DUE TO (c) Diagnosis undetermined 223X	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Pulmonary abscess left lower lobe with left hemiplegia See Mo's	

19a. DATE OF OPERATION 7/19/52	19b. MAJOR FINDINGS OF OPERATION Left Acoustic neuroma	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE WORKING? <input type="checkbox"/> NOT WHILE WORKING? <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Pathologist** to _____, 19____, that I last saw the deceased alive on **9-12-1952**, and that death occurred at **11:45 pm.**, from the causes and on the date stated above.

23a. SIGNATURE W.R. McPhee	23b. ADDRESS Research Hosp. 2300 Holmes K.C. Mo	23c. DATE SIGNED 9/13/52
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24a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial	24b. DATE 9-15-52	24c. NAME OF CEMETERY OR CREMATORY Raymore MO	24d. LOCATION (City, town, or county) (State) Raymore MO
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DATE REC'D BY LOCAL REG. 9-15-52	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE France-Warvall	ADDRESS Funeral Home
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WRITE PLAINLY—USING UNEADING 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 *Russell N France*.....

Licensed Embalmer No. *4255*.....

P. O. Address *K.C., 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.