

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **11475**

No. 300
10.48

BIRTH (MO) **APR 27 1955** REG. DIST. NO. **114** PRIMARY REG. DIST. NO. **4486** Registrar's No. **27**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY FRANKLIN 0361	a. STATE MO	b. COUNTY FRANKLIN	b. COUNTY FRANKLIN
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN	c. LENGTH OF STAY (in this place) 11 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL R. 2	0360
d. FULL NAME OF HOSPITAL OR INSTITUTION NORTHSIDE	d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) ALLIE	b. (Middle) F.	c. (Last) FUNKHOUSER SR.	(Month) APRIL	(Day) 21	(Year) 1955
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED WIDOWED 2	8. DATE OF BIRTH FEB. 23, 1878	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	10b. KIND OF BUSINESS OR INDUSTRY BUILDING	11. BIRTHPLACE (State or foreign country) TULU, KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME JAMES CLINTON FUNKHOUSER	13b. MOTHER'S MAIDEN NAME SARAH INEZ JACOBS	14. NAME OF HUSBAND OR WIFE CALLIE FRANCES MEERKS
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 486-18-0421	17. INFORMANT'S SIGNATURE OR NAME Allie F. Funkhouser Jr.	ADDRESS St. Louis, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Peritonitis		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ruptured Cecum, gangrenous			1 Day
	DUE TO (c) Saddle Embolus of Aorta			11 Days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) 454 X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1953, to April 21, 1955, that I last saw the deceased alive on April 21, 1955, and that death occurred at 1:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert McCarroll M.D.	23b. ADDRESS Sullivan Mo	23c. DATE SIGNED April 21, 55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-25-55	24c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. 4/24/55	REGISTRAR'S SIGNATURE Thomas A. Humphrey	476	25. FUNERAL DIRECTOR'S SIGNATURE H. W. Eaton	ADDRESS Sullivan, Mo.
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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.