

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 21 1956

State File No. **41470**  
Registrar's No. **5284**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

|   |  |   |                                |
|---|--|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |                                |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>   |  | c. LENGTH OF STAY (in this place) <b>23 weeks</b>   | c. CITY OR TOWN <b>Raytown</b> |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b> |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>           |                                |
| e. STREET ADDRESS (If rural, give location) <b>9000 East 63rd. Street</b>   |  |   |                                |

|                                     |                         |                          |                             |   |
|-------------------------------------|-------------------------|--------------------------|-----------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Mamie</b> | b. (Middle) <b>Ethel</b> | c. (Last) <b>Funkhouser</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 5, 1956</b> |
|-------------------------------------|-------------------------|--------------------------|-----------------------------|---|

|                      |                               |  |                                      |   |   |   |
|----------------------|-------------------------------|--|--------------------------------------|---|---|---|
| 5. SEX <b>female</b> | 6. COLOR OR RACE <b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify), <b>never married</b> | 8. DATE OF BIRTH <b>May 12, 1892</b> | 9. AGE (In years last birthday) <b>64</b> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
|----------------------|-------------------------------|--|--------------------------------------|---|---|---|

|   |   |   |   |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>Mamouth Springs, Ark.</b> | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |
|---|---|---|---|

|   |  |   |
|---|--|---|
| 13a. FATHER'S NAME <b>Paul Funkhouser</b> | 13b. MOTHER'S MAIDEN NAME <b>Cordelia Huntsinger</b> | 14. NAME OF HUSBAND OR WIFE <b>none</b> |
|---|--|---|

|   |  |  |  |
|---|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Adda Rice</b> | ADDRESS <b>9010 E. 63rd. St. Raytown</b> |
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|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH <b>7 mo.</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of mouth &amp; throat - squamous cell</b>   |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |   |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <b>May 30. Biopsy + cauterization</b><br><b>Oct 30 - Left neck reaction</b> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|--|

|  |  |   |
|--|--|---|
| 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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from **May 1, 1956**, to **Dec 5, 1956**, that I last saw the deceased alive on **Dec 5, 1956** and that death occurred at **12:45 P.M.**, from the causes and on the date stated above.

|  |                     |                                      |                                 |
|--|---------------------|--------------------------------------|---------------------------------|
| 23a. SIGNATURE <b>John O. Skinner MD</b> | (Degree or title) D | 23b. ADDRESS <b>1402 Bryant Bldg</b> | 23c. DATE SIGNED <b>12-6-56</b> |
|--|---------------------|--------------------------------------|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> | 24b. DATE <b>12/7/56</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b> |
|---|--------------------------|--|---|

|   |  |   |   |
|---|--|---|---|
| DATE REC'D BY LOCAL REG. <b>12-6-56</b> | REGISTRAR'S SIGNATURE <b>Neva Marshall</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Earp &amp; Sons</b> | ADDRESS <b>4139 Truman Rd. K.C., Mo</b> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
John O. Skinner

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**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.....  
Signature of Student Embalmer

Signed.....  
*James W. Eap*  
Licensed Embalmer No.....462

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.