

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 16 1960

-60-015322

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2297 STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 70 years	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Linwood Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1639 Kensington Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First James Middle A. Last Funk			4. DATE OF DEATH Month April Day 24 Year 1960			
5. SEX Male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/29/1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self employed	11. BIRTHPLACE (City and state or country) Chillicothe, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Abson Funk		13b. MOTHER'S MAIDEN NAME Amanda Lewis		14. NAME OF HUSBAND OR WIFE Maggie Funk		

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. 496-05-0147	17. INFORMANT Address Frances Duffy 1639 Kensington K. C., Mo.	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 1 day 8 years
IMMEDIATE CAUSE (a) Cerebral Hemorrhage			
DUE TO (b) arteriosclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 2-11-60 to 4-24-60 and last saw her/him alive on 4-24-60
Death occurred at 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Frank Paul Laurenciana MD	22b. ADDRESS 428 S. White Ave	22c. DATE SIGNED 4-24-60
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4/26/60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
24. FUNERAL DIRECTOR ADDRESS Earp & Sons 4707 Truman Rd. K. C., Mo.		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

25. DATE RECD. BY LOCAL REG. 4-25-60	26. REGISTRAR'S SIGNATURE Neva Minshall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank Paul Laurenciana

*Dr. J. J. ...
Mason ...*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James W. Eay*

Licensed Embalmer No. 4622
P. O. Address M. C., Md.

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.