

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-024079

LED VS JUN 21 1960

STATE FILE NUMBER

DED

Registration District No. 277 Primary Registration District No. 4411 Registrar's No. 23

| | | | | | | | | |
|---|---|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Pike</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ralls</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bowling Green</u> | | Length of stay in lb <u>3 yrs.</u> | | c. CITY OR TOWN <u>Hannibal, Mo.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pike co. Nursing Home</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>Marktwain Home</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Nancy Marie Funk</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 15, 1960</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-29-1865</u> | 9. AGE (last birthday) <u>94</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | 11. BIRTHPLACE (City and state or country) <u>Pittsfield Ill.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Samuel Atwood</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Eliza Jane Cheffey</u> | | 14. NAME OF HUSBAND OR WIFE <u>Abraham Funk</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>No</u> | 17. INFORMANT <u>Nursing Home Record</u> Address <u>Bowling Green Mo.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Cardiac Degeneration</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>1 yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arthritis Hefomone, Arterio Sclerosis</u> | | | | | | 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 Month, Day, Year a.m. p.m. | | | | | | | | |
| 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 | | |
| 21. I attended the deceased from <u>1958</u> to <u>6-15-60</u> and last saw her alive on <u>6-13-60</u> Death occurred at <u>7:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Deceased or title) <u>J. M. Mathews W.P.</u> | | | | 22b. ADDRESS <u>Bowling Green Mo</u> | | 22c. DATE SIGNED <u>6-15-60</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>6-17-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Oakwo od</u> | | 23d. LOCATION (City, town, or county) (State) <u>Pittsfield, Ill</u> | | | | |
| 24. FUNERAL DIRECTOR <u>Sutter Funeral Home</u> ADDRESS <u>Pittsfield Ill</u> | | | 25. DATE RECD. BY LOCAL REG. <u>JUNE 15, 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Maidie E. Williams</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold C. King

Licensed Embalmer No. 459

P. O. Address Bowling

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.