

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027648

AMENDED FILED AUG 3 1961 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2003 STATE FILE NUMBER

DATE AMENDED  
7 9 61  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		Length of stay in 1b <b>3 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5528A ROBIN</b>
3. NAME OF DECEASED (Type or print) First <b>ALVIN</b> Middle <b>A.</b> Last <b>FUNKE</b>			4. DATE OF DEATH Month <b>7</b> Day <b>16</b> Year <b>1961</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>Separated</b>	8. DATE OF BIRTH <b>7-27-18</b>
9. AGE (last birthday) <b>42</b>		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) <b>Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bettendorf-Rapp</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>AUGUST H. FUNKE</b>	
13b. MOTHER'S MAIDEN NAME <b>JOSEPHINE SCHENCK</b>		14. NAME OF HUSBAND OR WIFE <b>PEARL L. FUNKE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>YES WW-II</b>		17. INFORMANT Address <b>St. Louis, Mo.</b> <b>JOSEPHINE G. FUNKE 5528A Robin</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			<b>30 DAYS</b>
DUE TO (b) <b>HEMORRHAGE FROM VARIX OF ESOPHAGUS</b>			<b>4 YEARS</b>
DUE TO (c) <b>LAENNECS CIRRHOSIS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>5811</b>			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 <b>7-13-61</b> to <b>7-16-61</b> and last saw <del>him</del> <sup>her</sup> alive on <b>7-16-61</b> Death occurred at <b>1:55</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Emmett D. Wall</b> (Degree or title)		22b. ADDRESS <b>M.D. VET. ADM. HOSP., JEFF. BRKS., MO.</b>	22c. DATE SIGNED <b>7-17-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>7-19-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc. 2161 E. Fair Ave.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-18-61</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy Med.</b>

**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 W. J. Bandy  
Licensed Embalmer No. 4202

P. O. Address St. Louis

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.