

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10316-61-038571 STATE FILE NUMBER

FILED NOV 10 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri.</u> | | Length of stay in 1b <u>2 weeks</u> | c. CITY OR TOWN <u>Stanton</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>805 N. Edwardsville</u> |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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| 3. NAME OF DECEASED (Type or print) | First <u>Charles</u> | Middle <u>Metheus</u> | Last <u>Funken</u> | 4. DATE OF DEATH | Month <u>November</u> | Day <u>4</u> | Year <u>1961</u> |
|-------------------------------------|----------------------|-----------------------|--------------------|------------------|-----------------------|--------------|------------------|

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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|
| 5. SEX <u>Male</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>9/27/1889</u> | 9. AGE (last birthday) <u>72</u> | IF UNDER 1 YEAR Months <u>..</u> Days <u>..</u> | IF UNDER 24 HR Hours <u>..</u> Min. <u>..</u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u> | 11. BIRTHPLACE (City and state or country) <u>Germany</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Peter Funken</u> | 13b. MOTHER'S MAIDEN NAME <u>Unavailable</u> | 14. NAME OF HUSBAND OR WIFE <u>Christina Funken, dec'd</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>Nil</u> | 16. SOCIAL SECURITY NO. <u>Nil</u> | 17. INFORMANT Address <u>Carl Funken, 3849 Hartford Street.</u> |
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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 |
| IMMEDIATE CAUSE (a) | <u>ASPIRATION PNEUMONIA, BILAT.</u> | <u>2-3 WEEKS</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>BRONCHO-ESOPHAGEAL FISTULA</u> | <u>2-3 WEEK</u> |
| | DUE TO (c) <u>CARCINOMA OF ESOPHAGUS, ADVANCED</u> | <u>8-9 MOS.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>150+</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 |

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| 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.) |
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| 20c. TIME OF INJURY Hour <u>..</u> a.m. <u>..</u> p.m. <u>..</u> | Month, Day, Year |
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|--|--|------------------------------|--------|-------|
| 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 ABOUT SEPT. 1, 61 to 11/2/61 and last saw her/him alive on 11/2/61 A.M.
Death occurred at 5:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Richard W. Gore M.D.</u> | 22b. ADDRESS <u>52 Maryland Plaza</u> | 22c. DATE SIGNED <u>11/4/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE <u>11/7/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri.</u> |
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| 24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.,</u> | 25. DATE RECD. BY LOCAL REG. <u>NOV 6 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Roal Smith M.D.</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 John J. Raines
Licensed Embalmer No. 2408

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.