

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

18339

1. PLACE OF DEATH

County Jackson
Township Jackson
City Raytown (No. Raytown 4238)

Registration District No. 403
Primary Registration District No. 5227

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

Paul Funkhouser
(a) Residence. No. Raytown St. _____ Ward. _____

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cordelia A. Funkhouser

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 15 - 1851

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>80</u>	<u>0</u>	<u>2</u>	<u>15</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming - 1
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN), _____ (STATE OR COUNTRY) Virginia

10. NAME OF FATHER George

11. BIRTHPLACE OF FATHER (CITY OR TOWN), _____ (STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER Mary

13. BIRTHPLACE OF MOTHER (CITY OR TOWN), _____ (STATE OR COUNTRY) Virginia

14. INFORMANT Maime Funkhouser (Address) Raytown

15. FILED 5-2-31 W. W. Scobbs, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1 1931

17. I HEREBY CERTIFY, That I attended deceased from Apr 11 1931, to May 1 1931, that I last saw him alive on May 1 1931, and that death occurred, on the date stated above, at 1.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute myocarditis
131
957
Chronic Interstitial Nephritis
(SECONDARY)
(duration) 4 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical signs
(Signed) W. W. Scobbs M. D.

5-2-1931 (Address) Raytown Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL May 3 1931

UNDERTAKER Rose & Henderson ADDRESS X.P. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 26 1931

