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.

MAY 25

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

Do not use this space. 44

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 14658

Township ..... Primary Registration District No. 1003 Registered No. 3845

City St Louis, (No. City Hospital St. ..... Ward)

2. FULL NAME Joseph B. Funke

(a) Residence, No. 7116 Idaho St., 1 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Susan Funke

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Feb. 22, 1870

7. AGE: YEARS 64 | MONTHS 1 | DAYS 25 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: none
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

FATHER

13. NAME: Burkhart Funke
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

MOTHER

15. MAIDEN NAME: Christine Ocole
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Susan B. Funke 7116 Idaho

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Hope DATE 4-18, 1934

19. UNDERTAKER (ADDRESS): Southern Und. Co. 6322 S. Grand

20. FILED ..... 19 ..... J. F. Bredeck Registrar. 4/17/34

MEDICAL CERTIFICATE OF DEATH

No physician in attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 4-16, 1934

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above at 4:23 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy

Date of onset

Other contributory causes of importance:

Lobar pneumonia
chronic Myocarditis

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ✓ Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ✓

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) [signature] M. D.

(Address) [illegible]