. No. 2
—1/47
5-17-39

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26811

Registration District No. FILED AUG 16 1947

Primary Registration District No. 1000

Registrar's No. 950

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rose Nursing Home
624 Prospect
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 mos. 4
(Specify whether years, months or days)
In this community: 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 624 Prospect Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Edith Delotter Funk
3. (b) If veteran, name war: No
3. (c) Social Security No.: None

4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Kaufman E. Funk
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: July (Month) 23 (Day) 1863 (Year)

8. AGE: Years 84 Months 0 Days 11 If less than one day hr. min.

9. Birthplace: Montgomery County (City, town, or county) Ohio (State or foreign country)
10. Usual occupation: At home
11. Industry or business: At home

FATHER
12. Name: Asron Delotter
13. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name: Cecilia Alford
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Nelson E. Funk
(b) Address: Springfield, Ohio.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/5/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: Heaton-Bowman
(b) Address: St. Joseph, Mo.
19. (a) 8-11-47 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature) 587

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4 year 1947 hour minute 10:20 A.M.
21. I hereby certify that I attended the deceased from June 1, 1947, to Aug 2, 1947, that I last saw alive on Aug 12, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial failure	2 days
Pulmonary Congestion	2 wk
Due to: Chronic Myocarditis	6 yrs
Due to: Senility	5 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 0
Of autopsy: 0

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: Dan Chaber M.D.
Address: 415 Felix Valentine Bldg. St. Joseph, Mo. Date signed: 8/6/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 William Spalding Registered Apprentice No. 28, working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th, St. Joseph, Mo

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 this body is not embalmed, fact should be so stated above.