FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 12 1948
Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 24296
Registrar's No. 6758

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ST. LOUIS 96
(c) City or town ~~St. Louis~~ FERGUSON 6
(If outside city or town limits, write "RURAL")
(d) Street No. 132 So. Clark Ferguson Mo. 2
(If rural, give location)
(e) N.R. Citizen of foreign country? ____ (Yes or No) 1
If yes, name country ____

3. (a) PRINT FULL NAME Mamie Funke
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex female 1
5. Color or race white
6. (a) Single, widowed, married, divorced married 1
6. (b) Name of husband or wife Edward H. Funke
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased July 20, 1882 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
66	~~10~~ 0	10	____ hr. ____ min.

9. Birthplace St. Louis, Mo. 0 (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ____
FATHER
12. Name Wm. Meehan
13. Birthplace St. Louis mo. 0 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Unk
15. Birthplace St. Louis, Missouri 0 (City, town, or county) (State or foreign country)
16. (a) Informant Elmer Funke, son
(b) Address 132 So. Clark Ferguson, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/48 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Sullivan's
(b) Address 2849 No. Euclid
19. (a) AUG 1 - 1948 (Date received local registrar) (b) J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30th year 1948 hour 1 minute 15 pm. M.
21. I hereby certify that I attended the deceased from June 30, 1948 to July 30, 1948 that I last saw her alive on July 30, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Cystitis - Catarrhal	
Due to Pancreatitis and hypertension	
Due to Arterio Sclerosis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to 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 S. H. Pranger (M. D. or other) M.D.
Address 4952 Maryland Date signed 7-30-48

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Robt L. Brinkm

Licensed Embalmer No. 3553

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 44

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 675-8

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mamie Funke

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased July 20 (Month) (Day) 1882 (Year)

8. AGE: Years 66 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) AUG 14 1948 (Date received local registrar) (b) J. A. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-24296