

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7305

State File No.

BIRTH NO. FILED MAR 5 1954 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 5 57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2019	
b. CITY (If outside corporate limits, write RURAL and give township) Lemay		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lemay Nursing Home		d. STREET ADDRESS (If rural, give location) 6726 Idaho	

3. NAME OF DECEASED (Type or Print) a. (First) MINNIE b. (Middle) *** c. (Last) FUNKE			4. DATE OF DEATH (Month) (Day) (Year) Feb. 27, 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Aug. 22, 1867		9. AGE (In years last birthday) 86		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	

13a. FATHER'S NAME Henry Linstroth		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Fred	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Irma Funke	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) None		18. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Irma Funke	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) None		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy			INTERVAL BETWEEN ONSET AND DEATH 28 days
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) CardioVascular Renal Disease			2 years
		DUE TO (c) Senility			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 442x		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 3/26, 1952, to 2/27, 1954, that I last saw the deceased alive on 2/20, 1954, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE <i>H. Benjamin</i>		23b. ADDRESS 7430 Virginia Avenue		23c. DATE SIGNED 2/27/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 2, 1954		24c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	
				24d. LOCATION (City, town, or county) (State) 1800 Lemay Ferry Road	

DATE REC'D BY LOCAL REG. 3-1-54		REGISTRAR'S SIGNATURE <i>Herbert P. Dombke</i>		25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister	
				ADDRESS U. & L. Co. 7814 So. Broadway St. Louis, Mo.	

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

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

Student Embalmer

Signed

Linus C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 8th Broadway

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.