

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014983

STATE FILE NUMBER  
2 3813

FILED MAY 6 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

300  
-57  
0  
911  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4515a Alice Avenue</b>		Length of stay in 1b <b>1 year</b>	d. STREET ADDRESS (If outside, give location) <b>4515a Alice Avenue</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>H.</b> Last <b>Funke</b>	4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1959</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11 1882</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supply Mgr. (Retired)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Famous-Barr Co</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Joseph G. Funke</b>	13b. MOTHER'S MAIDEN NAME <b>Josephine Klevorn</b>	14. NAME OF HUSBAND OR WIFE <b>Never Married</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>488-03-2314</b>	17. INFORMANT <b>Miss Dorothy Funke, 4515a Alice Avenue</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from **Feb 28, 1958** to **April 15, 1959** and last saw him alive on **April 15, 1959**  
Death occurred at **3:40 PM** m in the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Laura R Allen MD</b>	22b. ADDRESS <b>4155 N. Newbould</b>	22c. DATE SIGNED <b>4-17-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 20, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Galvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
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24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, I c., 2161 E. Fair</b>	25. DATE RECD. BY LOCAL REG. <b>APR 17 '59</b>	26. REGISTRAR'S SIGNATURE <b>Karl Smith M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

2186

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 .....  
Signature of Student Embalmer

Signed *W. G. & Burnley* .....  
Licensed Embalmer No. *4207* .....  
P. O. Address *Albany, N.Y.* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.