

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-035006

STATE FILE NUMBER

FILED VS OCT 6 1959

Registration District No. 370 Primary Registration District No. 6250 Registrar's No. 23

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Wayne</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Wayne</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hiram</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Hiram</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home (Cowan)</u>		Length of stay in lb <u>8 Mo</u>		d. STREET ADDRESS (If outside, give location) <u>Cowan Township</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles H. Funkenbush</u>				4. DATE OF DEATH Month Day Year <u>Sept. 19 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8-1877</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (City and state or country) <u>Lewis Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>William Funkenbush</u>			13b. MOTHER'S MAIDEN NAME <u>Henrietta Wagner</u>			14. NAME OF HUSBAND OR WIFE <u>Florence Mileham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>318-12-6711</u>		17. INFORMANT Address <u>R. V. Shanks Canton, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
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.)				
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	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>5:00 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>M. E. Bowler</u> <u>Coroner</u>				22b. ADDRESS <u>Piedmont, Mo</u>		22c. DATE SIGNED <u>Sept. 30, 1959</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Clark, Co. Mo.</u>		
24. FUNERAL DIRECTOR <u>William Cooker</u>			ADDRESS <u>1145 Green</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 3-59</u>	26. REGISTRAR'S SIGNATURE <u>Hertle M. Ward</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 Coder Funeral Home, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed William Coder

Licensed Embalmer No. 3723

P. O. Address Quincy, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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