

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004564

FILED VS FEB 15 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 284 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Manchester</b>		Length of stay in 1b <b>4 Months</b>	c. CITY OR TOWN <b>Sycamore Hills</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>Pine Crest Nursing Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS <b>2500 Brown Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Funk</b> Last <b>Funk</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>27</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1924 1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Nicholas Mangin</b>			13b. MOTHER'S MAIDEN NAME <b>Josephine Martin</b>		14. NAME OF HUSBAND OR WIFE <b>The Late August Funk</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Emma Funk 2500 Brown Rd.</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>Hypertensive Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
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.)	
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20c. TIME OF INJURY. Hour _____ a.m. _____ p.m. _____	Month, Day, Year <b>9-1-59</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis County Mo.</b>	COUNTY <b>St. Louis County</b>	STATE <b>Mo.</b>
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21. I attended the deceased from 9-1-59 to 1-27-60 and last saw her/him alive on 1-20-60  
Death occurred at 7:36 a.m. 1-27-60 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Allen McHearney M.D.</b>		(Degree or title)		22b. ADDRESS <b>4308 Epeter St. St. Louis, Mo.</b>		22c. DATE SIGNED <b>1-28-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/29/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	

24. FUNERAL DIRECTOR <b>Collier Mortuary, St. Ann, Mo.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1-28-60</b>		26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>	
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Sheldon Collier

Licensed Embalmer No. 338

P. O. Address S. T. Amm

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.