

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 11 1960

60-008228

STATE FILE NUMBER

2, 2466

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Length of stay in 1b	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6527 Goethe		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EMIL First F Middle FUNK Last			4. DATE OF DEATH Month FEB. Day 29 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/19/90	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Insurance	11. BIRTHPLACE (City and state or country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Emil Funk Sr.		13b. MOTHER'S MAIDEN NAME Minnie Fussner		14. NAME OF HUSBAND OR WIFE Rose (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Robert Funk 830 Hawkins Court	
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>intra cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>Vascular hypertension</u> DUE TO (c) <u>331x</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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 <u>2/28/60 7:45P</u> to <u>2/29/60</u> and last saw her/him alive on <u>2/29/60</u> Death occurred at <u>10:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Robert K. Lane M.D.</i>			22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 2/29/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/3/60	23c. NAME OF CEMETERY OR CREMATORY New Pickers Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo	
24. FUNERAL DIRECTOR ADDRESS Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. MAR 2 1960		26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i> m JB	

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 Harley R. Jaeller Jr
Licensed Embalmer No. 4950
P. O. Address St. Louis

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.