

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**43102**

1. PLACE OF DEATH  
 County Schuyler Registration District No. 206  
 Township Prarie Primary Registration District No. 6052  
 City Near University St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Wm Glen Funk  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Male  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (with the word) Widower  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wife Dead  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR)  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
80 9 26  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work. Sawmill man  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 2 1929  
 17. I HEREBY CERTIFY, That I attended deceased from Nov 7, 1929, to Dec 2, 1929, that I last saw him alive on Nov 30, 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Causer of Stomach  
W  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTOR (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) Penn  
 (STATE OR COUNTRY)  
 10. NAME OF FATHER Henry Funk  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Penn  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) Geo King, M. D.  
 , 19 \_\_\_\_\_ (Address) Queen City Mo

14. INFORMANT W. H. Funk  
 (Address) Kirksville mo  
 15. FILED \_\_\_\_\_, 19 \_\_\_\_\_ REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Queen City Mo DATE OF BURIAL Dec 3 1929  
 20. UNDERTAKER Wm A West ADDRESS Queen City Mo

N. B. - If supplied, AGE should be stated. Exact statement of OCCUPATION is very important. Cause of death may be properly classified.

PROPERTY OF THE U.S. GOVERNMENT  
EXACT COPY AS SUPPLIED

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Schuyler  
Township Pacific  
City..... (No..... St..... Ward)

Registration District No. 806  
Primary Registration District No. 6052

File No.....  
Registered No.....

**2. FULL NAME**

Wm. Glenn Frank

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-6-1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
80 9 26

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED..... 19.....  
J. P. Jones REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 2 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-43102