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

Do not use this space.

33003

File No. 3935

Registered No.

1. PLACE OF DEATH
County Jackson
Registration District No. 399
Township Kaw
Primary Registration District No. 1002
City Kansas City, Mo. (No. Trinity Lutheran Hospital St. Ward)

2. FULL NAME Marietta Miss Marietta Funk Funk
(a) Residence, No. Fontana - Ks. St., Ward. Fontana, Ks.
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 20, 1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	24	11	16	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School Teacher
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

FATHER
13. NAME William T. Funk
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

MOTHER
15. MAIDEN NAME Nellie Brand
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

17. INFORMANT (ADDRESS) Mrs. Bessie C. Smith Muncie Ks.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Fontana, Ks. DATE Oct. 9-1933

19. UNDERTAKER (ADDRESS) Hesser, Undertaker La Cygne, Ks.

20. FILED 10/ 1933 M. M. Crowe Asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 6, 1933

22. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1933, to Oct 6, 1933
I last saw her alive on Oct 6th, 1933. Death is said to have occurred on the date stated above, at 12 25 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Nephritis	
1398	
130	

Other contributory causes of importance:
Operation
1830

Name of operation Left Salpingectomy Date of
What test confirmed diagnosis? Was there an autopsy No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ✓ Date of injury ✓, 19
Where did injury occur? ✓
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. ✓
Manner of injury ✓
Nature of injury ✓

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) John H. Overland, M. D.
(Address) 1025 Rialto Bldg

CAUSE OF DEA[illegible]

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..... Registration District No..... File No.....

Township..... ~~Primary Registration District No.~~..... Registered No. 3935

City..... (No. Trinity Hospital St. ..... Ward)

2. FULL NAME Marietta Turk.

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
F	Wh	Single

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

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

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
24	11	16	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

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

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT..... (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19....

19. UNDERTAKER..... (ADDRESS)

20. FILED 10/6 19 33 M. M. Crowe Coroner Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6, 1933

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute nephritis	
Chronic Tonsillitis	
Adenoids	

Other contributory causes of importance:

Operation

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

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

(Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

NOTE: Every item of information should be stated. Nothing should be left blank. Write plainly in ink. Use only regular terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. .....

City ..... (No. ..... St. ..... Ward)

2. FULL NAME .....

(a) Residence: (No. ..... St. ..... Ward.
(b) Inside city limits? ..... (If rural, 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 foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

6a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF .....

S-33003

6b. DATE OF BIRTH (MONTH, DAY, AND YEAR) .....

7. AGE — YEARS ..... MONTHS ..... DAYS ..... If less than 1 day, hrs. ..... min. .....

8. OCCUPATION .....

9. INDUSTRY .....

10. Total number of children ..... Number living ..... Number deceased .....

11. Place of death (e.g., residence, institution, place of business, etc.) .....

12. Place of injury (e.g., farm, factory, street, office, etc.) .....

13. Was death caused by accident, suicide, or homicide? .....

14. Was injury received while at work? .....

15. Was injury received while in military service? .....

16. Was injury received while in U. S. Merchant Marine? .....

17. Was injury received while in U. S. Navy, Marine Corps, Coast Guard, or Reserve? .....

18. Was injury received while in U. S. Army or Air Corps? .....

19. Was injury received while in U. S. Air Force? .....

20. Was injury received while in U. S. Coast Guard? .....

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