

FILED APR 8 1940

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

10551
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 135
 (b) Township _____ Primary Registration District No. 3010 Registered No. 29
 (c) City or Town Carrollton (d) Street No. South Side Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jacob O. Frank

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 17 - 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. retired
 9. Industry or business in which work was done, as 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) Bosworth Miss.

FATHER 13. NAME Leover K. Frank

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

MOTHER 15. MAIDEN NAME Rebecca Frank

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

17. INFORMANT (ADDRESS) Mrs. M. W. Meinerd
948 N. Belcher Wichita Kan.

18. BURIAL, CREMATION, OR REMOVAL PLACE Wm. Fry DATE Feb. 28 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) David J. Edwards
Bosworth

20. FILED _____ 19 _____
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 26 1940

22. I HEREBY CERTIFY, That I attended deceased from July 4 1940, to Feb. 26 1940.
 I last saw him alive on Feb. 26 1940. 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:

Mitral Regurgitation
Fasciitis ex-spensator
 Date of onset _____
 Other contributory causes of importance: A2W

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. W. Meinerd, M. D.
130 (Address) Carrollton

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X16605

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 4-2-40

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

....., Registered Apprentice No.

working under my personal supervision.

Signed

David J. Edwards

Licensed Embalmer No. *3265*

P. O. Address *Bosworth Ind*

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10537

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 135

Primary Registration District No. 3010

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Carroll
(b) City or town: Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Jacob O. Funk

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex: m 5. Color or race: w 6. (a) Single, widowed, married, divorced: wid
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, alive: years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 71 Months - Days 9 If less than one day in min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.

18. (a) Signature of funeral director. (b) Address
19. (a) 3-11-1940 (Date received local registrar) (b) Ruth Haskins (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.
(c) City or town. (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U.S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 26 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above. Immediate cause of death

Due to.
Due to.
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. Of autopsy. PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).
(b) Date of occurrence.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.
23. Signature: R. M. Benson (M. D. or other) Address: Carrollton

SUPPLEMENTARY

UNITED STATES GOVERNMENT
BUREAU OF INVESTIGATION

CONFIDENTIAL

[Faint, mostly illegible typed text, likely a cover letter or report header]

[Faint, mostly illegible typed text, likely the main body of a report]

S-10551 - 1940

CONFIDENTIAL - (S) - (U) - (C) - (R) - (E) - (N) - (T) - (I) - (A) - (L) - (S) - (E) - (D) - (E) - (D)