

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

Do not use this space.

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**1. PLACE OF DEATH**

County Jackson Registration District No. 877  
Township Kaw Primary Registration District No. 9729  
City K.C. (No. 608 Beacon) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Earl Clyde Parker  
(a) Residence No. 608 Beacon 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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 2, 1890</u>		
7. AGE	YEARS	MONTHS
	<u>32</u>	<u>7</u>
		<u>28</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Carpenter</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

**MEDICAL CERTIFICATE OF DEATH**

3  
16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 1923  
17. I HEREBY CERTIFY, That I attended deceased from June 29 to June 30, 1923, to June 30, 1923, that I last saw him alive on June 30, 1922, and that death occurred, on the date stated above, at 7:25 a.m.  
THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
adhesive Peritonitis (Suetie)  
(duration) 4 yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Incompetency of Right Heart  
(duration) \_\_\_\_\_ yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Kaw  
10. NAME OF FATHER D. J. Parker  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo.  
12. MAIDEN NAME OF MOTHER Mary Waters  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) N. G.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH, don't know  
DID AN OPERATION PRECEDE DEATH? no. DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no.  
WHAT TEST CONFIRMED DIAGNOSIS? X Ray and Laboratory  
(Signed) W. Warren, M. D.  
(Address) 416 Euclid Bldg  
\*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. (See reverse side for additional space.)

14. INFORMANT D. J. Parker  
(Address) 608 Beacon Ave.  
15. FILED 7/2 23 M. M. Creech  
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mr Haslington DATE OF BURIAL July 2, 1923  
20. UNDERTAKER C. H. Blackman & Son ADDRESS 6606 Grand

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

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# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, Carcinoma, Sarcoma*, etc., of..... (name given; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or recurrent) affection need not be stated unless important. Example: *Measles* (disease causing death 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Coma," "Coma," "Debility" ("Congenital," "Senile," "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., which definite disease can be ascertained as the cause. Always qualify all diseases resulting from congenital birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause of death which surgical operation was undertaken. VIOLENT DEATHS state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by way train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicidal*. The nature of the injury, as fracture of skull and its consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by the Committee on Nomenclature of the American Medical Association.)

**NOTE.**—Individual offices may add to above list of suitable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificate will be returned for additional information which gives the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, diarrhoea, gangrene, gastritis, erysipelas, meningitis, miscellaneous necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will result in vast improvement, and its scope can be extended at a future date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

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