LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

—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.

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

35225

1 PLACE OF DEATH

County: Macon

Township: White
or
Village: Ethel
or
City: ..... (NO. ....., ... St.; ..... Ward)

Registration District No. 531 File No. 2

Primary Registration District No. 4317 Registered No. 28

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME: Isaac Sidwell Parker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word): widowed

6 DATE OF BIRTH: May (Month) 7 (Day), 1832 (Year)

7 AGE: 92 yrs. 7 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS

10 NAME OF FATHER: John Parker

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): New York

12 MAIDEN NAME OF MOTHER: Deborah Wells

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lizzie Parker
(Address): Ethel Mo

15
Filed: Dec 8, 1924. J. M. Greenman, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 7 (Day), 1924 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug —, 1914, to Dec 7, 1924, that I last saw him alive on Dec 7, 1924, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:
Senile - nephritis
12 yr
1 d
1 hr
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Senility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed): W E Brady M. D.
Dec 7, 1924 (Address): Ethel Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State 72 yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? yes
Former or usual residence: Ethel Mo —

19 PLACE OF BURIAL OR REMOVAL: Glaston Mo
DATE OF BURIAL: Dec 7, 1924

20 UNDERTAKER: J. E. Gilleard
ADDRESS: New Cambria Mo

New Cambria Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7 AGE .....yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h..... alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

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

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS