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

Do not use this space.

21490

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. [illegible]
Township Kaw — Primary Registration District No. 1002 — Registered No. [illegible]
City Kansas (No. Old City Hospital St. ..... Ward)

2. FULL NAME Jack Parks
(a) Residence. No. ..... St., ... Ward. Excelsior Springs
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR ~~RACE~~: ed
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

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

7. AGE: about 40 — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) Elms Hotel
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Maggie Parker
(Address) Excelsior Springs

15. FILED 7/18, 1927 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-16 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-13, 1927, to 7-16, 1927 that I last saw h.[illegible] alive on 7-16, 1927, and that death occurred, on the date stated above, at 4:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paresis of the Insane.

83 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 76 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical finding +
(Signed) Lab. H. M. Smith, M. D
7/17, 1927 (Address) Old City Hospital.

*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: Excelsior Springs — DATE OF BURIAL: July 20 1927

20. UNDERTAKER: H B Moore — ADDRESS: 1820 E 18

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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.