JAN 6 1928

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

Do not use this space.

34433

1. PLACE OF DEATH

County Ray — Registration District No. 740 — File No.

Township Crooked River — Primary Registration District No. 5975 — Registered No. 55

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

2. FULL NAME Chas Edward Parker

(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: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married.

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Fanny Francis Parker

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan-16-1856

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Carroll Co Mo

PARENTS

10. NAME OF FATHER: John Parker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Dont No

12. MAIDEN NAME OF MOTHER: Dont No

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont No

14. INFORMANT: Florence E Howe
(Address): Kansas City Mo

15. FILED Nov 10, 1927 Jno W. Knipschild REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) ✓ 19

17. I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1927, to Nov. 10, 1927, that I last saw him alive on Nov. 10, 1927, and that death occurred, on the date stated above, at 9:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial nephritis
Chronic myocarditis
(3)
936 (duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) [signature] (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Course

(Signed) Carl H Reed, M.D

, 19 (Address) Hardin

*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: Hardin Cem — DATE OF BURIAL: Nov-11 1927

20. UNDERTAKER: Jno W. Knipschild — ADDRESS: Hardin Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

11-27

1. PLACE OF DEATH.

County Ray — Registration District No. 740 — File No.

Township Crooked river — Primary Registration District No. 5-973- — Registered No. 3-3-

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

2. FULL NAME Chas Edward Parker

(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) |
|---|---|---|
| M | W | M |

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. |
|---|---|---|---|---|
| | | | | |

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

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Dec 10 1927 Jno W. Kruprchild REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 10. 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

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

, 19 (Address)

*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 | DATE OF BURIAL 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

SUPPLEMENTARY

N. B. ... CAUS... ...rms, so that it may ... REGISTRARS RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS ... B ... W

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