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

Do not use this space.

36915

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City (No. ..... St. ..... Ward)
Registration District No. 399
Primary Registration District No. 1002
St Mary's Hospital
File No. 1400
Registered No. 7800

2. FULL NAME Peter Cartright Folker
(a) Residence. No. Lenexa Kansas 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 Anna D Folker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-31-1857

7. AGE Years 69 Months 11 Days 15 If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER Ina H Folker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Van Buren Co
(STATE OR COUNTRY) Iowa
12. MAIDEN NAME OF MOTHER Matilda Ross.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Iowa
(STATE OR COUNTRY)

14. INFORMANT A. D. Folker
(Address) 612 W Chicago Ave Chicago Ill.

15. FILED 12/15 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec-15 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1927, to Dec 15, 1927 that I last saw him alive on Dec-15-1927, and that death occurred, on the date stated above, at 11:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Labor Pneumonia
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Lymphatic Leukaemia
(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) P. L. Jones, M. D
Dec 15, 1927 (Address) Lenexa Kansas

*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 Lenexa Kansas
DATE OF BURIAL 12/17 1927

20. UNDERTAKER H. E. Julien
ADDRESS Olathe Kas

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.