JAN 25 1929

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

Do not use this space. 2666

~~41827~~

File No. .....

Registered No. .....

1. PLACE OF DEATH
County New Madrid — Registration District No. 604
Township " " " — Primary Registration District No. 5802
City " " " (No. ....., ... St. ..... Ward)

2. FULL NAME Mrs. Amanda 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 60 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Negro

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

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rev. W. H. Parker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1811

7. AGE: Years about 60 — Months Est. — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: his wife
(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) Mo.

PARENTS

10. NAME OF FATHER Andrew Jackson

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

12. MAIDEN NAME OF MOTHER Susie [illegible]

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) New Madrid, Mo

14. INFORMANT Rev. W. H. Parker
(Address) 5534 Wal[illegible] St. Louis

15. FILED 1/14/1929 W. D. Bannon, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-14th 1929

17. I HEREBY CERTIFY, That I attended deceased from 8-7, 1928, to 8-10, 1928, that I last saw her alive on 8-10, 1928, and that death occurred, on the date stated above, at 6:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senility
Hemiplegia
(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (SECONDARY) General Decay of Life (duration) yrs. 8 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) J. D. Farris, M. D.
, 19 (Address) New Madrid Mo

*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 Powell Cem. — DATE OF BURIAL 1-15th 1929

20. UNDERTAKER Richardson & Co — ADDRESS New Madrid

N. B. — supplied. AGE should be stated in years, months and days if under 1 year. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

72
7
2
23

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County New Madrid — Registration District No. 604 — File No. 9
Township 7 7 — Primary Registration District No. 5802 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Amanda 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: F
4. COLOR OR RACE: B
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk. 1871

7. AGE — YEARS: About 58 — MONTHS: Unk. — 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 1/14/1929 W. O. Bannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/14 1929

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

5-2666