

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

Do not use this space.

6802

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 1003
 City Kansas City (No. 4017 - East 39 St) Registered No. 968
 St. 16th Ward

2. FULL NAME Mary E Parsons
 (a) Residence No. 4017 2 39 St. 16th Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 12 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 30 1846

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>82</u>	<u>8</u>	<u>29</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
 (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) Missouri

10. NAME OF FATHER Edwin Moss

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

12. MAIDEN NAME OF MOTHER Nancy Parish

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

14. INFORMANT J. Parsons
 (Address) 4017 2 39 St

15. FILED 7-27-29 19. M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 19 29

17. I HEREBY CERTIFY Deputy Coroner That I attended deceased from 19... to 19... that I last saw him... alive on... 19... and that death occurred, on the date stated above, at... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
131
93C

CONTRIBUTORY (SECONDARY) Chronic valvular
nephritis (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At Home

DID AN OPERATION PRECEDE DEATH? DATE OF... WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? History Inspection
 (Signed) Henry M. Wall M. D.
7-27-29 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Leige Mo DATE OF BURIAL Feb 28 19 29

20. UNDERTAKER H C Bergman ADDRESS Kans City Mo

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.

235
1
2
2

