

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

Do not use this space.

14998

1. PLACE OF DEATH

County Jackson
Township Law
City K.C., Mo. (No. General Hospital #2)

Registration District No. 399
Primary Registration District No. 002

File No. 2060
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Eva Parks Williams
(a) Residence, No. 7801 Linwood Blvd. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1887

7. AGE YEARS 42 MONTHS _____ DAYS _____ If LESS than 1 day, hrs. _____ or min. _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER William Parks

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

12. MAIDEN NAME OF MOTHER Interson

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

14. INFORMANT William Parks
(Address) 7801 Linwood Blvd.

15. FILED 5/2, 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-30-29

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:

Accidental - Automobile
fractured leg (duration) yrs. mos. da. _____

CONTRIBUTORY Kans City, Mo (SECONDARY) (duration) yrs. mos. da. _____

18. WHERE WAS DISEASE CONTRACTED 1810
IN NOT IN PLACE OF DEATH _____

DIETARY OPERATION PRECEDE DEATH. _____ DATE OF 4/30/29

19. WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) [Signature], M. D.
(Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or if 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 Highland Cemetery DATE OF BURIAL 4/3 1929

20. URBERTAKER West, Apoliter & Jones ADDRESS 1600 E 19th St

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.

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DATE 1964