

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

Do not use this space.

33729

**1. PLACE OF DEATH**

County Jackson  
Township KAW  
City Kansas City

Registration District No. 399  
Primary Registration District No. 1002  
(No. 4003 Bellefontaine)

File No. \_\_\_\_\_  
Registered No. 4181  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Kate Virginia Parsons  
(a) Residence. No. 4003 Bellefontaine St. 16 Ward.  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 24, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
69 10 12

**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**

Michael Rinfrock

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Pennsylvania

**12. MAIDEN NAME OF MOTHER**

Susan B. Currie

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Virginia

**14.**

INFORMANT Ralph K. Parsons  
(Address) 4003 Bellefontaine

**15.**

FILED 10/8 19 29 M. M. Conner  
REGISTRAR

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**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 6, 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1929, to Oct 6 1929 that I last saw him alive on Oct 5 1929, and that death occurred, on the date stated above, at 3:25 A. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Supratentorial brain tumor  
81A

107A (duration) yrs. mos. 3 ds.

CONTRIBUTORY Lateral Sclerosis of Cord  
(SECONDARY)

(duration) 1 1/2 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? \_\_\_\_\_

**WHAT TEST CONFIRMED DIAGNOSIS?**

Physical Exams  
(Signed) Eugene H. Ferguson, M. D.

10/7 19 29 (Address) 1810 W 4th St

\*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**

Wm. Washington Ave

10-8 1929

**20. UNDERTAKER**

**ADDRESS**

Shire & McCherie

3235  
William Pl

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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Dr. E..H. Ferguson,  
605 Bryant Bldg.,  
V1-1020