

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

Do not use this space.

38050

1. PLACE OF DEATH

County Pettis Registration District No. 672
 Township Wescher Primary Registration District No. 5895
 City (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 7

2. FULL NAME

Anna 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 25 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) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Parker
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 55
 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) (STATE OR COUNTRY) Bellevue Mo
 10. NAME OF FATHER Samuel Knight
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
 12. MAIDEN NAME OF MOTHER Don't know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Thomas Parker
 (Address) Wescher Mo

15. FILED Nov 25, 1929 J. Evans
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 21 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 1308 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Hemorrhage
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY T.B.
 (SECONDARY) (duration) _____ 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? no
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) [Signature], M. D.
11-23 .1929 (Address) Sudaria 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 Brookline DATE OF BURIAL Nov 27 1929

20. UNDERTAKER B. J. Parker ADDRESS La Monte Mo

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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