

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

Do not use this space.

1596

1. PLACE OF DEATH

County Jackson
Township Jackson
City K.C. Mo. (No. General Hosp # 2)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 428 St. _____ Ward)

2. FULL NAME

(a) Residence. No. Infant Parks St. 4/ Ward. _____
(Usual place of abode) 4618 Euclid (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 an 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-16-1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. #9

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Ernest Parks

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas City, Mo. (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Eva Fright

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kansas City, Mo. (STATE OR COUNTRY)

14. INFORMANT General Hosp # 2 (Address) Record Clerk

15. FILED 1/29/31 M. M. Crowe REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-25-1931

17. I HEREBY CERTIFY, That I attended deceased from 1-17-1931, to 1-25-1931 that I last saw her alive on 1-25-1931, and that death occurred, on the date stated above, at 5:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107A Broncho-Pneumonia
Primary (duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) 107A (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS _____ (Signed) D. M. Oulley, M. D. 126, 1931 (Address) Genl Hosp # 2

*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 Blue Ridge Lawn DATE OF BURIAL 1-28-1931

20. UNDERTAKER H. B. Moore ADDRESS 1820 E 18th

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. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

