NOV 21 1935

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

Do not use this space.

32747

1. PLACE OF DEATH
County Jackson — Registration District No. 1002 — File No.
Township Kaw — Primary Registration District No. — Registered No.
City Kansas City (No. K C Gen Hosp St. Ward)

2. FULL NAME Ida Parker
(a) Residence, No. 202 Independence St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 16 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 W.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm E Parker
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 11, 1895
7. AGE 5 — YEARS 40 — MONTHS 9 — DAYS 1 — If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER
13. NAME George Parker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
15. MAIDEN NAME Ollie McIntyre
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Record Clerk K C Gen Hosp KC Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Wash DATE Oct 14 1935
19. UNDERTAKER (ADDRESS) Rose & Henderson 15 & Jackson
20. FILED 10-14 1935 M. M. Crowe, asst. Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-12, 1935
22. I HEREBY CERTIFY, That I attended deceased from 10-8, 1935 to 10-12, 1935
I last saw her alive on 10-12, 1935 Death is said to have occurred on the date stated above, at 9:40 pm
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Tuberculous Pneumonia | |
| Toxemia of Pregnancy | |

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) [signature], M.D.
(Address) S. K C Gen Hosp KC 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.