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.

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

SEP 21 1937

Do not use this space.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 29957
Township Kaw — Primary Registration District No. 1002 — Registered No. 92
City K. C. Mo. (No. St Joseph Hospital St. Ward)

2. FULL NAME John Clayton Parker
(a) Residence, No. 4901 Wabash St., Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wh.
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): Aug 29-1937
7. AGE: YEARS 0 — MONTHS 0 — DAYS 0 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: —
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Infant
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): Kansas City Mo.

FATHER
13. NAME: Alden M. Parker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Fort Worth Texas

MOTHER
15. MAIDEN NAME: Louise Stuchell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Devon Kansas.

17. INFORMANT (ADDRESS): Alden M. Parker 4901 Wabash Ave.
18. BURIAL (CREMATION) OR REMOVAL
PLACE: Elmwood Mausoleum DATE: Aug 30 1937
19. UNDERTAKER (ADDRESS): Mrs. C. L. Forster 918 Brooklyn
20. FILED: Aug 30 1937 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug. 29 1937
22. I HEREBY CERTIFY, That I attended deceased from 8/29, 1937, to 8/29, 1937
I last saw him alive on ....., 19.... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:
Stillborn infant — Date of onset
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? No
If so, specify .....
(Signed) [signature] M. D.
(Address) St. Joseph Hospital Kansas City, Mo.