. No. 2
-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

SEP 5 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 27463

Registrar's No. 3096

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.Gen.Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. 3050 Oakley
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME WILL H. PARKER 626

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Margaret Parker

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Nov. 30, 1887
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
52	8	2	____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Self

FATHER
12. Name Samuel Parker
13. Birthplace ____ (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Caroline Stewart
15. Birthplace ____ (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Walter Parker
(b) Address 3050 Oakley K.C. Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 2, 40 (Month) (Day) (Year)
(c) Place: burial or cremation Lebanon Mo

18. (a) Signature of funeral director C. H. Blackmer Hos
(b) Address K.C. Mo.

19. (a) Aug. 2, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2nd year 1940 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from July 29th, 1940, to August 2nd 1940, 19__; that I last saw him alive on August 2nd, 1940, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac decompensation	
Due to 95 P.D.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy See above	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Drury R. Thorel (M. D. or other)
Address Med. Dir. K.C. Gen/Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Registered Apprentice No. ....., working under my personal supervision.

Signed H D Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.