

Registration District No. 404

Primary Registration District No. 5558

Registrar's No.

## 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:  
8310 Flora  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Since 1915  
 (Specify whether years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL.")  
 (d) Street No. 8310 Flora  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29  
 year 1941 hour 12 minute 59 A. M.

21. I hereby certify that I attended the deceased from  
Mar. 28 1941 to Mar. 29 1941  
 that I last saw him alive on Mar. 28 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia 5 days  
 Duration

Due to 100

Due to

Other conditions Chronic dyspepsia  
 (Include pregnancy within 3 months of death)

## PHYSICIAN

Major findings:  
 Of operations  
 Of autopsy

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?

3612  
 While at work? (Specify type of place) (c) Means of injury

23. Signature Ed Stinson (M. D. or other)  
 Address 80 E. Base Date signed 2/29/41

3. (a) PRINT FULL NAME Auby Park

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Single

6. (b) Name of husband or wife No 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased Feb. 14 1872  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 1 15  
 hr. min.

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

10. Usual occupation Confection Stone

## 11. Industry or business

12. Name Stephen Park

13. Birthplace Ky.  
 (City, town, or county) (State or foreign country)

14. Maiden name Matilda Brasfield

15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant Wm. Park

(b) Address 4204 Woodland

17. (a) Burial (b) Date thereof March 31 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Estis Cem. Kearney, Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn, K. C., Mo.

19. (a) 4-7-41 (b) R. Y. L. ... & Son  
 (Date received local registrar) (Registrar's signature)

Dr. George H. Jones

804 - Pease

JA 1879

2755

1934  
6/3/36

**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 Gerald J. Wade

Licensed Embalmer No. 4172

P. O. Address R. 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, fact should be so stated above.**

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4-41  
7-39  
X26390

Registration District No. 404

Primary Registration District No. 5538

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Waverly T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Auby Park

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 14 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 1 15 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 6-16-44 (b) Mr. J. T. Brennan  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Geo. Jones (M. D. or other) \_\_\_\_\_

Address 806 1/2 Paseo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

1941  
S-10942

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**