

FILED MAR 6 1943

State File No. _____

Registration District No. _____

Primary Registration District No. 3012

Registrar's No. 227

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 mos. 2 days
(Specify whether
In this community 5 mos. 2 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert M. Parker
3. (b) If veteran, name war World War I
3. (c) Social Security No. Yes, not remembered

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 18
year 1943 hour 7:15 minute A. M.

4. Sex Male Color or race white
5. Color or race white
6. (a) Single, widowed, married, divorced, divorced
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from September 16 1942 to February 18, 1943
that I last saw h. im alive on February 18 1943
and that death occurred on the date and hour stated above.

7. Birth date of deceased: August 20, 1895
(Month) (Day) (Year)

Immediate cause of death: Tuberculosis, pulmonary, chronic far advanced, active, severe
Duration unknown

8. AGE: Years 47 Months 5 Days 29
If less than one day _____ hr. _____ min.

Due to _____
Due to _____

9. Birthplace Independence, Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Furnace worker - unemployed
11. Industry or business _____
12. Name Robert Parker
13. Birthplace Canada
(City, town, or county) (State or foreign country)
14. Maiden name Nellie Herrington
15. Birthplace London England
(City, town, or county) (State or foreign country)

Other conditions: Tuberculous enteritis and Tuberculous Laryngitis
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations: _____
Of autopsy: No autopsy

16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.
(b) Address Removal
17. (a) Removal (b) Date thereof 2-18-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Independence, Mo.
18. (a) Signature of funeral director: Claude Prichard
(b) Address Excelsior Springs, Mo.
19. (a) 2-18-43 (b) Mrs. Sadie Redman
(Date received local registrar) (Registrar's signature)

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)
(c) Means of injury _____
Signature Forrest G. Bell (M.D. or other) M.D.
Address Veterans Administration Date signed 2-18-43

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 13-4-43

gives
cert

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

Robert Kay
.....
Licensed Embalmer No. 4182

P. O. Address Excelsior Springs, 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.