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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29831

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4101

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C. Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K. C. Convalescent Hosp. 4 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8-24-45 - 10-1-45 (Specify whether In this community since 1935 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 118

(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL")

(d) Street No. unknown 8 (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Marie Parks

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced unk 9

6. (b) Name of husband or wife

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

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant K. C. Convalescent Hosp. 1

(b) Address 3200 Norledge

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-4-45 (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence, Kansas

18. (a) Signature of funeral director Dixon L. Kepley

(b) Address Sidep. Mo

19. (a) 10-5-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2 year 1945 hour 6:10 minute a M.

21. I hereby certify that I attended the deceased from 8-24-45, 19, to 10-2-45, 19; that I last saw her alive on 10-1-45, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death) 97	
Major findings: Of operations	
Of autopsy	

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 J. Lawrence Ave (M. D. or other)

Address 3200 Norledge Date signed 10-5-45

(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 Dupre L. Kepley

Licensed Embalmer No. 4225.

P. O. Address Indep. 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.