

FILED SEP 14 1946

State File No. _____

Registration District No. 296

Primary Registration District No. 4445

Registrar's No. 28

1. PLACE OF DEATH:

(a) County RAY
(b) City or town Orriek
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community all of life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray
(c) City or town Orriek Mo.
(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 IDA PARKER

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married divorced
6. (b) Name of husband or wife John W. Parker 6. (c) Age of husband 83 years April 19 1863 (Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Jesse Sutton
13. Birthplace Orriek, Mo. (City, town or county) (State or foreign country)
14. Maiden name Ellen Vignale
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Cheshire
(b) Address Orriek, Mo.
17. (a) Burial (b) Date thereof 8-29-46 (Month) (Day) (Year)
(c) Place: burial or cremation South Point

18. (a) Signature of funeral director J. W. Good
(b) Address Orriek, Mo.
19. (a) 8-30-46 (Date received local registrar) (b) Ellen C. Parker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26 year 1946 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 1-1946 19 to Aug 26/46 19; that I last saw her alive on Aug 26/46 19; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Calcicosis Duration _____

Due to Chronic Nephritis
Due to Hypertension

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations B/A

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? _____

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

23. Signature J. T. Summers (M. D. or other) MD
Address Orriek, Mo Date signed 8/29/46

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

RECEIVED

District Health Officer No. 8

District File Number.....

Date Filed 7-14-16

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.....

.....
Self
working under my personal supervision.

....., Registered Apprentice No.....

Signed *Victor E. Amunigac*

Licensed Embalmer No. 2896

P. O. Address Liberty, 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.