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DEPARTMENT OF COMMERCE
FEDERAL BUREAU OF THE CENSUS
FILED NOV 12 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33714**
Registrar's No. **4585**

Registration District No. **149**

Primary Registration District No. **1002**

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:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **12 DAYS** (Specify whether
In this community **1 YR.** 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. **2916 BENTON PLAZA**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **ROSETTA PARKER**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **FEMALE**

5. Color or race **NEGRO**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **JOEL PARKER**

6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **SEPTEMBER 27, 1889**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCTOBER** day **29**, year **1946** hour **11**: minute **50** P.M.

21. I hereby certify that I attended the deceased from **OCTOBER 17, 1946**, to **OCTOBER 29, 1946**; that I last saw h **ER** alive on **OCTOBER 29, 1946**, and that death occurred on the date and hour stated above.

Immediate cause of death **DIABETIC ACIDOSIS**

8. AGE:

Years	Months	Days	If less than one day
57	1	2	hr. min.

Due to **DIABETES MELLITUS**
HYPERTENSIVE HEART DISEASE

Due to

Other conditions (Include pregnancy within 3 months of death)

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

10. Usual occupation **HOUSEWIFE**

Major findings:
Of operations **61**

Of autopsy

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

11. Industry or business

12. Name **DANIEL FRONIBERGER**

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

14. Maiden name **CLARISA SHUFFORD**

15. Birthplace **Hickory, North Carolina**
(City, town, or county) (State or foreign country)

16. (a) Informant **JOEL PARKER (HUSBAND)**

(b) Address **2915 BENTON PLAZA**

17. (a) **Burial** (b) Date thereof **11/1/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetery**

18. (a) Signature of funeral director **Wathins**

(b) Address **1729 Lydia Avenue**

19. (a) **10-31-46** (b) **Thalaine Holmes**
(Date received local registrar) (Registrar's signature)

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

23. Signature **Frank** (M. D. or other) **M. D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **10/30/46**

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

J. J. Manlove

Licensed Embalmer No. *3994*

P. O. Address *5503 Highland*

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.**