

No. 2
5-43
17-39
X36671

FILED MAR 21 1947

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
220 1/2 West Lexington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 50 Years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME William E. Parker

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

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

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

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

8. AGE: Years 86 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Salesman

11. Industry or business Davis Clothing Co.

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown (State or foreign country)

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

16. (a) Informant Mrs. Geo. Hare

(b) Address 311 South Main, Indap. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-1947 (Month) (Day) (Year)

(c) Place: burial or cremation Poplawn Cem

18. (a) Signature of funeral director [Signature] (b) Address Independence, Missouri

19. (a) 2-26-47 (Date received local registrar) (b) [Signature] (Registrar's signature)

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. 220 1/2 West Lexington
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9th year 1947 hour 9 minute 32 A. M.

21. I hereby certify that I attended the deceased from Sept, 1946 to Feb 9, 1947 that I last saw live on Feb 8, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration sudden
Due to arteriosclerosis chronic

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: [Signature]
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? _____

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

23. Signature J. H. Hackerson (M. D. or other) _____
Address Independence, Mo Date signed Feb 10

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.....

R. B. Griffith

....., Registered Apprentice No. *451*

working under my personal supervision.

Signed.....
Dixon L. Kelsey

..... Licensed Embalmer No. *4225*

P. O. Address.....
Independence, 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.

Registration District No. 146 Primary Registration District No. 3026

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(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)

3. (a) PRINT FULL NAME Wm E. Parker
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 _____ (Month) (Day) (Year)

8. AGE: Years 86 Months _____ Days _____ If less than one day _____ yr. _____ min.

9. Birthplace St. Louis, Mo. (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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 4/10/47 (Date received local registrar) (b) James Craig (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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

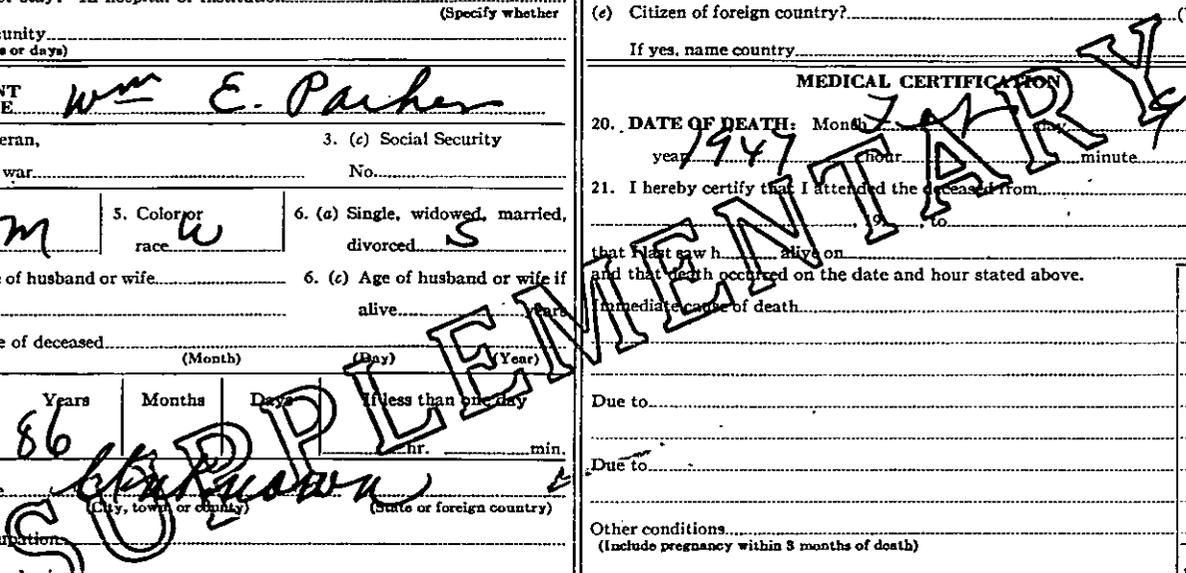
PHYSICIAN

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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



9545