

Registration District No. 149

Primary Registration District No. 1002

State File No. \_\_\_\_\_

Registrar's No. 4984

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: D. O. Hosp. 11th, & Harrison  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 Days (Specify whether D)  
In this community 25 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
48  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL") 3  
(d) Street No. 1518 Corrington  
(If rural, give location) 5  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emory L. Parks  
(b) If veteran, name war No  
(c) Social Security No. 486-07-5358

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 5th,  
year 1948 hour 10 minute 35A. M.

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife Bess Parks  
6. (c) Age of husband or wife if alive Unknown years  
7. Birth date of deceased Sept. 30th, 1897  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 4 1948 to Dec 5 1948  
that I last saw him alive on Dec 5 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
51 2 5 hr. min.

Immediate cause of death Cerebral Hemorrhage Duration 3 days

9. Birthplace Missouri (City, town, or county) (State or foreign country)  
10. Usual occupation American Roofing Corp.

Due to Malignant Hypertension 18 mos

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name Robert W. Parks  
13. Birthplace Penn. (State or foreign country) 1  
14. Maiden name Nancy Jane King  
15. Birthplace Ill. (State or foreign country) 1

Other conditions Congestive Heart Failure, Chronic Glomerulo-  
(Include pregnancy within 3 months of death)  
Major findings: NEPHRITIS PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Mabel Grout  
(b) Address 1518 Corrington Ave.  
17. (a) Burial (b) Date thereof 12/7/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Wash. Cem.  
18. (a) Signature of funeral director Earp & Sons  
(b) Address 4139 East 15th, St.  
19. (a) 12-6-48 (b) Steraldine Holman  
(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?  
Maurice M. Geraghty  
While at work? (Specify type of place) (e) Means of injury 2  
Signature Maurice M. Geraghty (M. D. or other) Dr  
Address 6045 EAST N. E. MO Date signed 12/6/48

Dr. H. L. Anthony  
15<sup>th</sup> & Walnut  
City, Mo. Mon.

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.....

*William H. Day*

Registered Apprentice No. *241*

working under my personal supervision.

Signed

*John B. Day*

Licensed Embalmer No. *2555*

P. O. Address. *K. C. 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.**