N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D MAR 9 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. 5684

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City K C Mo
Registration District No. 399
Primary Registration District No. 1002
Registered No. 883
(d) Street No. K C Gen Hospt St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jack Park
(a) Residence, No. 10 - Paseo. Park View Hotel St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nancy Jane Park
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April-5-1916
7. AGE YEARS 22 MONTHS 10 DAYS 22 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Paint Co
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo 0

FATHER
13. NAME Eli Park 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Liberty Mo

MOTHER
15. MAIDEN NAME Bessie Armstrong
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo

17. INFORMANT (ADDRESS) Record Clerk K C Gen Hospt
18. BURIAL, CREMATION, OR REMOVAL
PLACE Liberty, Mo DATE Mar 1 1939 Fairview
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Church - Archer Co Liberty Mo
20. FILED 2/27 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-27-39 19

22. I HEREBY CERTIFY, That I attended deceased from 2-23-39, 19..., to 2-27-39, 19...
I last saw him alive on 2-27-39, 19..... Death is said to have occurred on the date stated above, at 5 30 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	
108	

Other contributory causes of importance:

Name of operation ..... Date of ..... nw
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) P. A. De Maria M. D.
Supt. K C Gen Hosp
K C Mo

(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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.