

1360 SEP 6 1939

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

28103  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 299  
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 3105  
 (c) City Kansas City, Mo. (d) Street No. 3939 Wyoming 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. da.

2. PRINT FULL NAME Mrs Ida Ellen Parr  
 (a) Residence, No. 3939 Wyoming St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Dalphius Parr

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 18, 1870

7. AGE YEARS 69 MONTHS 16 DAYS 10 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Sawyer

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

12. BIRTHPLACE (CITY OR TOWN) Tower Hill (STATE OR COUNTRY) Ill

FATHER 13. NAME David Jester (STATE OR COUNTRY) Ohio

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)

17. INFORMANT Ralph Parr (ADDRESS) 3939 Wyoming

18. BURIAL, CREMATION, OR REMOVAL PLACE Neosho, Mo. DATE 8-4-39

19. FUNERAL DIRECTOR (NAME) Thos. E. Quirk (ADDRESS) 4316 Troost

20. FILED 8-4-39 M. D. Carr Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-4-39, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 31, 1939, to Aug. 4, 1939  
 I last saw her alive on Aug. 4, 1939. Death is said to have occurred on the date stated above, at 5 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Myocardial failure -  
Hypertension - Small  
Cerebral hemorrhage  
 Date of onset July 31

Other contributory causes of importance: 8-4-39

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 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? Yes  
 If so, specify \_\_\_\_\_  
 (Signed) Thos. E. Quirk M. D.  
 (Address) 242 Plaza Medical Bldg

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.

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**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 comply with the above constitutes grounds for revocation of license.)**

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