

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

**13795**

Do not use this space.

**1567**

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002 Registered No. \_\_\_\_\_  
 (c) City Kansas City (d) Street No. St. Joseph Hosp. Linnwood Hospital 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**

(a) Residence, No. 1208 ADMIRAL BLVD 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 Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Parker  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 19-1889  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
40 yrs 9 17

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 9. Industry or business in which work was done, as saw mill, bank, etc. Drown Cab Co.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas 1

FATHER  
 13. NAME Robert P. Parker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo 0

MOTHER  
 15. MAIDEN NAME Ella Potter 0

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

17. INFORMANT (ADDRESS) Sarah Parker  
1208 Admiral

18. BURIAL, CREMATION OR REMOVAL PLACE St. Mary's DATE 4/18-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Thompson  
1208 Admiral

20. FILED April 7, 1940 M. M. Brown  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 5, 1940

22. I HEREBY CERTIFY, That I attended deceased from April 3, 1940, to April 5, 1940.  
 I last saw him alive on April 4, 1940. Death is said to have occurred on the date stated above, at 1:45 Am.  
 The principal cause of death and related causes of importance were as follows:

Cerebral degeneration  
Subacute Bacterial Endocarditis  
Myo  
of

Date of onset 4-5 days

Other contributory causes of importance:  
Vegetative endocarditis of mitral & aortic valve

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis B. actina Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? none (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none  
 Nature of injury \_\_\_\_\_

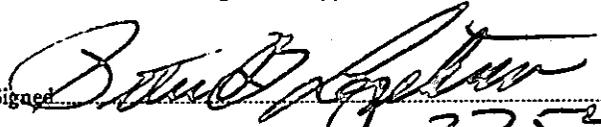
24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_ (Signed) John D. Shaver M. D.  
 (Address) 1402 Bryant Bldg. N.C.M.D.

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.

**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. 3754

P. O. Address KC

**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.**