

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3154**

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 Research Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 Days
(Specify whether years, months or days)
 In this community 21 years

3. (a) PRINT FULL NAME Mr. David Elmer Parks 620

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Mrs. Minnie Parks 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased January 25 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>6</u>	<u>12</u>	hr. min.

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

10. Usual occupation Railroad Man

11. Industry or business Retired

MOTHER FATHER { 12. Name Manassa Parks

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Minnie Parks

(b) Address 912 Charlotte Street

17. (a) Burial (b) Date thereof Aug 8, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hiawatha, Kansas

18. (a) Signature of funeral director D. H. Newcomer son

(b) Address 1401 Brush Creek Blvd.

19. (a) Aug. 7, 1940 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 912 Charlotte Street
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? ---- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6th
 year 1940 hour 11 minute 07 P. M.

21. I hereby certify that I attended the deceased from July 18, 1940
 1940, to Aug 6, 1940;

that I last saw him alive on 8-6-40, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Leukemia - aleukemic Typhoid - Paratyphoid B?

Due to The final result will be

Due to to that until microscopic + bacteriological studies

Other conditions of the previous same
(Include pregnancy within 3 months of death)

Major findings: Enlarged spleen

Of operations: _____

Of autopsy: _____

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 Paul B. [unclear] (M. D. or other)

Address 924 Prof. Bldg. Date signed 8-7-40

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

924

924 - Professional Body
10:30

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 *Kenneth Page Sipe*

Licensed Embalmer No. 4129

P. O. Address 1309 Bush Creek K.C.M.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 275-21

Registration District No.

Primary Registration District No.

Registrar's No. 3154

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

1. PLACE OF DEATH:

(a) County
(b) City or town
(c) Name of hospital or institution: Research Hospital
(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 David E. Parker

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

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

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: 68 Years Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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) 9/2/40 (b) M. M. Crowe
(Date received local registrar) (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. 912 Charlotte
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years

20. DATE OF DEATH: Month Aug day 6
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19..... 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 Septicemia
Salmonella Enteritidis
Due to C. U. S. P. H. Washington D.C. 1 week

Due to
Other conditions Ch. Aleukemic Leukemia 1 yr.
(Include pregnancy within 3 months of death)

Major findings: Of operations 7/2/40
Of autopsy

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 Paul B. ... (M. D. or other)
Address 924 ... Date signed 9/20/40
K. C. ...

Duration
1 week
1 yr.
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-27521