

Registration District No. **431**

Primary Registration District No. **5595**

Registrar's No. **166**

I. PLACE OF DEATH:

(a) County Johnson
(b) City or town Warrensburg Rural - Simpson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna Young Parker 36
(b) If veteran, name war _____ (c) Social Security No. none

4. Sex Female 5. Color or race White
6. (b) Name of husband or wife Wm H. Parker
7. Birth date of deceased April 27 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 3 3 hr. min.

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

10. Usual occupation Housewife

MOTHER FATHER

12. Name Edgar Young
13. Birthplace New York (City, town, or county) (State or foreign country)
14. Maiden name Miss Murch
15. Birthplace North Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Wm H. Parker
(b) Address Wagonsville Mo
17. (a) Burial (b) Date thereof 8/1/1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Car Goodwin

18. (a) Signature of funeral director A. S. ...
(b) Address Wagonsville Mo
19. (a) Aug 30 - 1940 (b) Bertie Gentry
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
(c) City or town RR. Warrensburg MO
(If outside city or town limits, write "RURAL")
(d) Street No. RR - (If rural, give location)
(e) If foreign born, how long in U. S. A.? 6 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1940 hour 2 PM minute _____ M.
21. I hereby certify that I attended the deceased from June - 1940
_____ 19____ to July 30 1940
that I last saw him alive on 7-28-40 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 30 days
Due to arterial hypertension ?
arteriosclerosis ?
Due to _____
Other conditions Chronic Myocarditis ?
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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?
at work? (Specify type of place) (e) Means of injury _____
23. Signature R. M. Kersey (M. D. or other) MD
Address Warrensburg MO Date signed 7-31-40

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

RECEIVED
District Health Officer No. 8
District File Number 9-5-40
Date Filed

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 W.S. Wade

Licensed Embalmer No. 1419

P. O. Address Haygreenville, 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, above space should be left blank.