

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: St. Mary's Hospital  
(d) Length of stay: In hospital or institution 50 Yrs.  
In this community 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 2529 Benton Blvd.  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mr. Ambrose Parks

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife May Logan Parks 6. (c) Age of husband or wife if alive Dec years  
7. Birth date of deceased March 21 1865

8. AGE: Years 75 Months 8 Days 30 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Shelbyville, Tenn.

10. Usual occupation Real Estate Broker

11. Industry or business \_\_\_\_\_

12. Name A. L. Parks  
13. Birthplace Tennessee  
14. Maiden name Unknown  
15. Birthplace Unknown

16. (a) Informant Miss Margaret Parks  
(b) Address Kirkwood Mo.

17. (a) Burial (b) Date thereof Dec. 25 1940  
(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director W. H. Newcomer Sons  
(b) Address 1401 Brush Creek Blvd.

19. (a) 12-22-40 (b) M. M. Crowe

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 20th year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Nov 19, 1940, to Dec 20, 1940; that I last saw him alive on Dec 20, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Diagnosis was coronary occlusion

Due to 7:45  
Due to \_\_\_\_\_

Other conditions Had a suppurative cystotomy  
Hypertrophy of Prostate  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Diagnosis Pulmonary em - bolism

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 3/6!  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(a) Means of injury \_\_\_\_\_

23. Signature Clarence D. Cahell (M. D. or other) \_\_\_\_\_  
Address 1137 Wells Blvd. K.C. Mo. Date signed 12/21/40

Duration

PHYSICIAN

Underlines the cause to which death should be charged statistically.

*Spells Day*

**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 *Emile M. Calhoun*

Licensed Embalmer No. *3506*

P. O. Address *K E Ma.*

**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.**