

FILED FEB 7 1948
49

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 440

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 11 days
In this community as above
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Anna M. Parker

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

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife GEORGE D. PARKER
6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased 1 24 1915
(Month) (Day) (Year)

8. AGE: Years 35 Months 0 Days 4
If less than one day hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name WILLIAM M. OVERLY
13. Birthplace KY.
14. Maiden name MAUD KEEFER
15. Birthplace MO.

16. (a) Informant GEORGE D. PARKER
(b) Address SHACKELFORD, MO.

17. (a) removal (b) Date thereof 1-28-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Marshall, Missouri

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 1-31-48 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 97
(c) City or town Shackelford
(If outside city or town limits, write "RURAL")
(d) Street No. X
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 28
year 1948 hour 11:00 minute P. M.

21. I hereby certify that I attended the deceased from Jan 17th
1948, to Jan 28, 1948
that I last saw h. ER alive on Jan 28, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Thyroid crisis
Due to Thyroidectomy
Due to Toxic goitre
Other conditions: Toxic goitre
(Include pregnancy within 3 months of death)
Major findings: Toxic goitre
Of operation _____
Of autopsy _____

Duration _____
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (M. D. or other) MD
Address 1612 1/2 Park Bldg Date signed 1/30/48

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

Robert H. Reed

Dr. C. J. Hunt

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 *Robert H Reed*

Licensed Embalmer No. *3745*

P. O. Address *J.C. 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, fact should be so stated above.