WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

1 PLACE OF DEATH

County .....

Township or Village or City St Louis

Registration District No. 791 File No. 30644

Primary Registration District No. 1003 Registered No. 8544

(NO. 3217 R. Lawton St.; 17 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Bud Parker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Coll.

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June (Month) 8 (Day) 1872 (Year)

7 AGE 46 yrs. 9 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) St Louis

PARENTS

10 NAME OF FATHER Curtis Parker

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill.

12 MAIDEN NAME OF MOTHER Myria Minor

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ga.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myria Parker

(Address) 3217 R Lawton ave

15 Filed SEP 11 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 6 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 26, 1918, to Sept 6, 1918, that I last saw him alive on Sept 4, 1918, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23 A

28 (Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. C. Haskell M. D.

Sept 11, 1918 (Address) 3201 Sadelle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Hillsboro

DATE OF BURIAL 9/11, 1918

20 UNDERTAKER Peter Manuel

ADDRESS 4107 Finney

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ..... 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191..... that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS