

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

File No. **22959**

Township.....

Primary Registration District No.

Registered No. **6636**

City **502 Ave** (No. **City Hospital**)

St. Ward)

2. FULL NAME

Syman (Order) Parker

(a) Residence, No. **4525 Danmore** Ward **7**

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. **6** mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov 1 - 1874**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 8 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **carpenter**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois Parker**

10. NAME OF FATHER **Frank (Order) Parker**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

14. INFORMANT (Address) **City Hospital**

15. FILED **JUL 21 1927** 19. **Max B. Starnes** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 18 1927**

17. I HEREBY CERTIFY That I attended deceased from **July 12**, 19**27** to **July 15**, 19**27** that I last saw h. l. **alive** on **July 18**, 19**27** and that death occurred, on the date stated above, at **11 - 08** a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
Chronic Nephritis
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED **1290**
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF

19. WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **Chas. H. ... M.D.**
(Address) **City Hospital**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDE.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL (DATE OF BURIAL) **Memorial Park July 21 1927**

20. UNDERTAKER **Walt Stuart** ADDRESS **5525 Easton**

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.

Poster