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

Do not use this space.

38905

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 11645

City St Louis Mo. (No. Barnes Hospital St. ..... Ward)

2. FULL NAME Aubrey Charles Parsons

(a) Residence. No. 1417a N. Newstead St., 11 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 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 Oneida Parsons

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 31 1874

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
53	4	27	

8. OCCUPATION OF DECEASED

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

(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) Miss

PARENTS

10. NAME OF FATHER Jos Parsons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

14. INFORMANT Oneida Parsons
(Address) 1417a No Newsted.

15. FILED DEC 28 1927, 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-27 1927

17. I HEREBY CERTIFY, That I attended deceased from 12-1, 1927, to 12-27, 1927, that I last saw him alive on 12-27, 1927, and that death occurred, on the date stated above, at 3:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis, Hypertrophy of Heart, Hypertension, Cardiac Decompensation
..... (duration) ..... yrs. 18 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Coronary Embolism
..... (duration) ..... yrs. ..... mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 73 C 95 B 74 B

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) George S Little, M.D.

12/27, 1927 (Address) Barnes 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 HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Weir Miss

DATE OF BURIAL Dec. 30 1927

20. UNDERTAKER Wm. F Paschedag.

ADDRESS 2825 No Grand.

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.