

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

Do not use this space.

38958

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

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

File No.

Registered No. 11627

2. FULL NAME Caroline Parker

(a) Residence. No. 3608 Tolson St. 17 Ward.

Length of residence in city or town where death occurred 8 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND~~ (OR) WIFE OF Joseph M. Parker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 14th 1912

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 8 25

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Perth Amoy (STATE OR COUNTRY) Chin.

10. NAME OF FATHER Cyrus Farmer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Logan County (STATE OR COUNTRY) Penn.

12. MAIDEN NAME OF MOTHER Jane Knight

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Perth Amoy (STATE OR COUNTRY) Chin.

14. INFORMANT John E. Purfer (Address) 434 N. 27th St

15. FILED 1928 REGISTRAR Wm E. Stanley

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-29 1928

17. I HEREBY CERTIFY That I attended deceased from 10-13, 1928 to 11-29, 1928 that I last saw h. Dr. alive on 11-29 at 10 a.m. and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Left Ovary

46 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 46 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) David H. Duke M. D. (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 East St. Louis DATE OF BURIAL Dec 2nd 1928

20. UNDERTAKER H.W. Niedefeld ADDRESS East St. Louis

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.

