

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

Do not use this space.

43654-42 ¹²⁹

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City..... (No.....)

File No. F 72

Registered No. F 72

St. _____ Ward _____

2. FULL NAME Lucinda Parker

(a) Residence. No. 1316th Wash St., 215 Ward.

(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

Female

4. COLOR OR RACE

Col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Clarence Parker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

abt 43

8. OCCUPATION OF DECEASED

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

House Wife

(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)

Coile
Mass

10. NAME OF FATHER

Steve Branch

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

12. MAIDEN NAME OF MOTHER

Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

14. INFORMANT

(Address)

FILED

David (State) Lauffer
210 S. 10th St.

15. REGISTER

FILED

-2 1378
May O. [Signature]

REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 27 1928

17.

I HEREBY CERTIFY, That I attended deceased from 12/25, 1928, to 12/27, 1928. that I last saw him alive on 12/27, 1928, and that death occurred, on the date stated above, at 8:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Angina Pectoris

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) B. W. [Signature], M. D.

, 19 (Address) 932 E. N 14th St

*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

Father Deacon

DATE OF BURIAL

Jan 2 1929

20. UNDERTAKER

American Under

ADDRESS

809 - N 19th

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.

