

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

Do not use this space.

2095

1. PLACE OF DEATH

County Jefferson
Township Sparks
City Desoto (No. _____)

Registration District No. 420
Primary Registration District No. 3000

File No. _____
Registered No. 17
St. _____ Ward _____

2. FULL NAME

Robert Eugene Parker

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident give city or town and State)

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 Permelia Parker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 18 1860

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 0 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rooming house operator
(b) General nature of industry, business, or establishment in which employed (or employer) Lincoln Co Mo
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lincoln Co Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER T. J. Parker

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT Mrs. Parker
(Address)

15. FILED 1/23 29 D. W. Pauggly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 23 1929

17. I HEREBY CERTIFY, That I attended deceased from 11/16/29 to 1/22 1929.
that I last saw him alive on 1/22 29, and that death occurred, on the date stated above, at 2:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11. Labor Pneumonia
108 (duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) 0 yrs. 0 mos. 7 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? usual clinical
(Signed) Walter E. Eyster Jr. M. D.
, 19 (Address) 16 Boyds, Desoto, Mo.

*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 Wentfield Mo. DATE OF BURIAL 19

20. UNDERTAKER R. Coxwell & Son ADDRESS _____

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.

RECORD

18 22 1929
50
22
7

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jefferson Registration District No. 420 File No. _____
 Township _____ Primary Registration District No. 3032 Registered No. 17
 City Desoto (No. _____) St. _____ Ward _____

2. FULL NAME Robert Eugene Parker

(a) Residence No. _____ St. _____ 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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M.
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 20-1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 | 5 | 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rooming House (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Em.
 (STATE OR COUNTRY)

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14.

INFORMANT _____
 (Address)

15.

FILED 3/14/29 J. L. Raugley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 22 1929 19

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____, since on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

_____, 19____ (Address)

*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

DATE OF BURIAL

Winfield Mo.

1/25/29

20. UNDERTAKER

ADDRESS

J. Corwell & Son

Desoto Mo

B.—Every item of information should be careful. CAUSE OF DEATH in plain terms, so that it may be understood. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. THIS IS A PERMANENT RECORD.

S-2095