

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

Do not use this space.

30436

1. PLACE OF DEATH
 County Davis Registration District No. 253
 Township Harrison Primary Registration District No. 5354
 City _____ No. _____ St. _____ Ward _____

2. FULL NAME Robert Dent 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 44 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Carrie Parker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 16 1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>45</u>		<u>28</u>	

8. OCCUPATION OF DECEASED.
 (a) Trade, profession, or particular kind of work Labor
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Samuel Parker

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

12. MAIDEN NAME OF MOTHER Elizabeth Hopkins

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

14. INFORMANT Carrie Parker
 (Address) Breckwidge Mo.

15. FILED 9-15-29 A. J. Minich
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 11:50 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidentally killed, head
crushed by dump car, while on
duty, instant death. yrs. mos. da.

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

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 clinical
 (Signed) The Gardner M. D.

(Address) Gallatin Mo. Deputy Coroner

*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 Rose Hill Cemetery DATE OF BURIAL Sept 15 1929

20. UNDERTAKER A. McPeak Breckwidge Mo. 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.

2-1-23

**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 Davis
Township Harrison
City (No.)

Registration District No. 253
Primary Registration District No. 9-354

File No.
Registered No. 8
St. Ward

2. FULL NAME

Robert Dent 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (<i>write the word</i>) <u>M</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, <u> </u> hrs. or <u> </u> min.
<u> </u>				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS	10. NAME OF FATHER <u> </u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u> </u> (STATE OR COUNTRY) <u> </u>
	12. MAIDEN NAME OF MOTHER <u> </u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u> </u> (STATE OR COUNTRY) <u> </u>

14. INFORMANT
(Address)

15. FILED 11/10, 1929 A. G. Thimich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13 1929

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Accidentally killed, head crushed by dump car wheel on duty of RR. worker

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) 245, 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 <u> </u>	DATE OF BURIAL <u> </u> 19 <u> </u>
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20. UNDERTAKER <u> </u>	ADDRESS <u> </u>
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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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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