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

Do not use this space.

2601

1. PLACE OF DEATH
County St Louis — Registration District No. 1160 — File No.
Township Central — Primary Registration District No. 4470 — Registered No. 5
City University City (No. 7350 Dorsett St. Ward)

2. FULL NAME Paul D Parker
(a) Residence. No. 7350 Dorsett 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: 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 May Parker

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

7. AGE: 45 YEARS — MONTHS: 4 — DAYS: 10 — If LESS than 1 day, ...hrs. or ....min.

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

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Lafayette Parker
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Wisconsin
12. MAIDEN NAME OF MOTHER Mary F Meyers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) West Virginia

14. INFORMANT Mrs May Parker
(Address) 7350 Dorsett

15. FILED 1-20, 1930 Lena V. Mueller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1930

17. I HEREBY CERTIFY, That I attended deceased from 10-6, 1929, to 1-18, 1930 that I last saw him alive on 1-18, 1930, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic diffuse nephritis
131
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 129 AL
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH St Louis
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Examination
(Signed) Walter H Spoeneman, M. D.
1-18, 1930 (Address) 1506 St Louis Ave

*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: Bellefontaine Cem — DATE OF BURIAL: Jan 21 1930

20. UNDERTAKER: A Kron L & U Co - 2709 — ADDRESS: N Grand

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County St. Louis — Registration District No. 1160 — File No.
Township — Primary Registration District No. 4470 — Registered No.
City University City — No. — St. — Ward)

2. FULL NAME Paul D. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 8, 1884

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
45	4	10	

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
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14.
INFORMANT
(Address)

15. FILED 3-13, 1930 Lena V. Moeller, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1930

17.
I HEREBY CERTIFY, That I attended deceased from ..., 19..., 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:

... (duration) ... yrs. ... mos. ... ds.

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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-2601