

SEP 24 1930

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

Do not use this space.

26539

1. PLACE OF DEATH

County Howe  
Township Union  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 390  
Primary Registration District No. 5545

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME William Robert Parmier

(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 Boy 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 20 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
16 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work child  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER Joseph H Parmier

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Iron Co Mo.  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Eva H Parmier

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Crawford Co Mo.  
(STATE OR COUNTRY)

14. INFORMANT Mrs Eva H Parmier  
(Address) Sabula Mo

15. FILED Sept 1, 1930 B C Hunter  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 1930

17. HEREBY CERTIFY, That I attended deceased from Aug 16, 1930, to Aug 18, 1930 that I last saw him alive on Aug 18, 1930, and that death occurred, on the date stated above, at 1 P. M. child.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Summer Complaint  
(Malignant diarrhoea)

CONTRIBUTORY (SECONDARY)

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 years  
(Signed) Edward H. Barnhouse M. D.

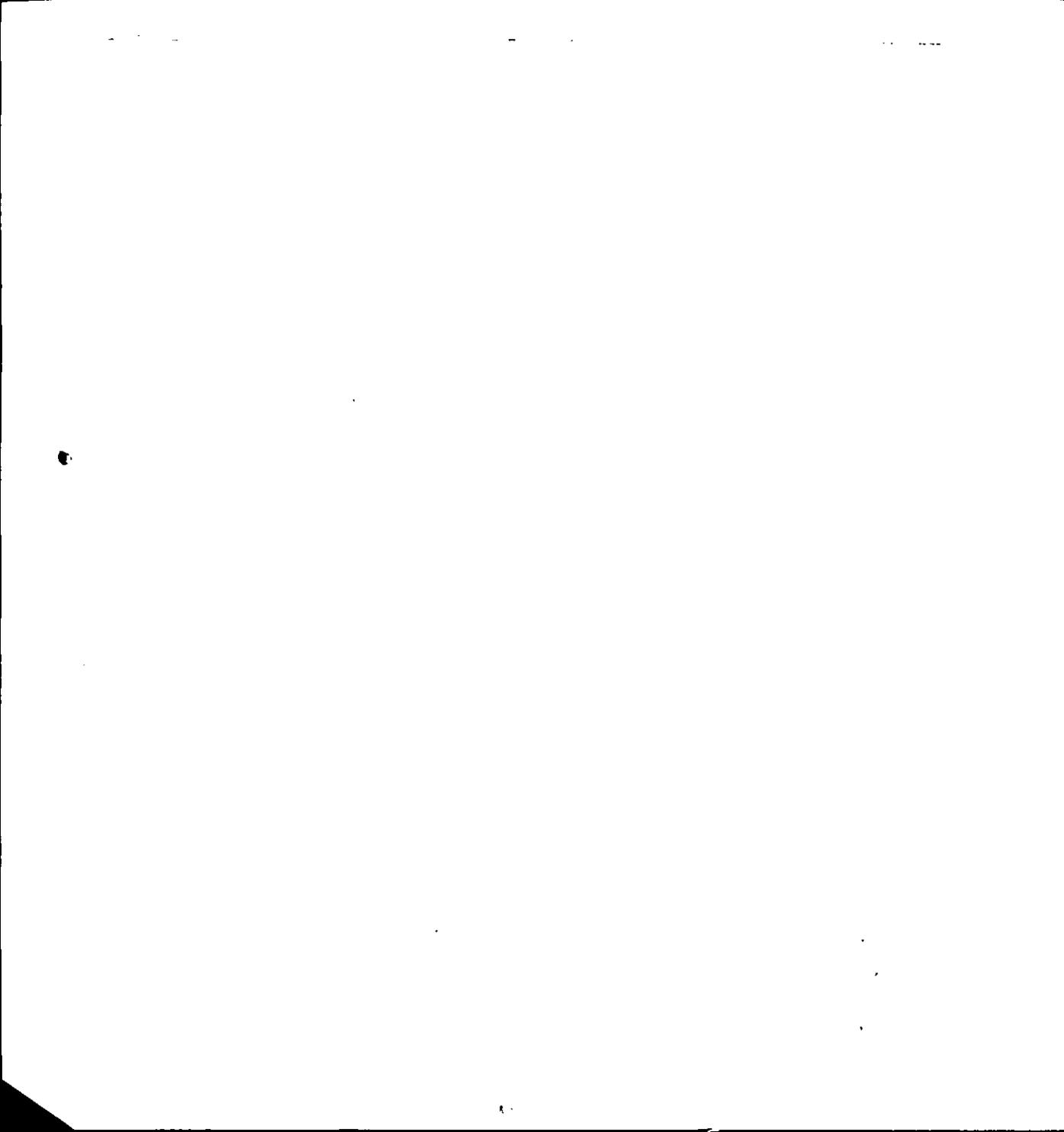
, 19 (Address) Winton Mo

\*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

Sabula DATE OF BURIAL Aug 21 1930

20. UNDERTAKER Relative ADDRESS Sabula Mo



**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 Don Registration District No. 390 File No. ....  
Township Union Primary Registration District No. 3343- Registered No. ....  
City (No. ....) St. .... Ward .....

**2. FULL NAME**

William Robert Parnen

(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 S  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 4 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
16 20

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (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) ..... (STATE OR COUNTRY) .....

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) .....  
FILED Oct 10 30 W.C. Genter REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 19 30

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

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

20. UNDERTAKER ADDRESS

**SUPPLEMENTARY**

REGISTERED TO RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAWS

S-24539