

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

Do not use this space.

1. PLACE OF DEATH

791

34313

County.....
Township.....
City.....

Registration District No. *1003*
Primary Registration District No. *St. Lukes Hospital*
(No.)

File No.
Registered No. *9664*
St. Ward)

2. FULL NAME

Mae Frances Parsons

(a) Residence, No. *5159 Westminster St.*, *12* 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *F*
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 *Dr. Scott Parsons*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 14 1872*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 6 25

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

10. NAME OF FATHER *J. G. Cephause*

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

12. MAIDEN NAME OF MOTHER *Laura Poorman*

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

14. INFORMANT *Dr. Scott Parsons*
(Address) *5159 Westminster St*

15. FILED *10* 19 *May 6* *Starckoff* REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct. 9 1930*

17. I HEREBY CERTIFY, That I attended deceased from *5:15 p.m. 16*, 19*30*, to *Oct. 9 1930*, that I last saw him alive on *Oct. 8 1930* and that death occurred, on the date stated above, at *4 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
7:30
10:15

CONTRIBUTORY (SECONDARY) *Chronic Bronchopneumonia*
(duration) yrs. mos. ds. *4*

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) *Walter Damminger, M.D.*

Oct. 9 1930 (Address) *Braunton Mch. Bldg*

*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 *Oct 11 1930*

20. UNDERTAKER *Philander Craig Washington*
ADDRESS *1426 E*

