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

Do not use this space.

41056

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1003~~

Township ..... Primary Registration District No. ..... File No. .....

Registered No. 11719

City St Louis Mo, (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Ewdard Parker

(a) Residence. No. 924a N. 22nd, St. St., 21 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)
Male	Colored	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt 1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt.	37	-	Unknown	

8. OCCUPATION OF DECEASED 108 1106

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9. BIRTHPLACE (CITY OR TOWN) Greenville
(STATE OR COUNTRY) Miss.

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Martha Williams

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

14. INFORMANT Katie Parker
(Address) 924 A N 22nd St.

15. FILED DEC 15 1930 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/12/ 1930

17. No Physician in Attendance

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 1 . P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

Pleurisy with Effusion

..... (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? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kemer, M.D.

12/13 1930 (Address) Dep. Corner

*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
Jefferson Barracks Mo	12/16 1930

20. UNDERTAKER	ADDRESS
Ellis Funeral Home	2820 Stoddard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.