

DEC 29 1937

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

Do not use this space.

1. PLACE OF DEATH

County *Washington*
Township *Hammontz*
City (No. _____) _____

Registration District No. *968*
Primary Registration District No. *4184*

File No. *42773*
Registered No. _____
St. _____ Ward _____

2. FULL NAME *Lawson W. Parmer*

(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 (write the word) *single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *single*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 4 1913*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
24 1 21

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Lutesville Mo*13. NAME *J. W. Parmer*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Emerson Mo*15. MAIDEN NAME *Mary Parmer*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Brennell Mo*17. INFORMANT (ADDRESS) *John Parmer*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Palmer* DATE *Mar 26 1937*19. UNDERTAKER (ADDRESS) *Stark*20. FILED *Dec 14 1937 Fannie Halman*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 24 1937*22. I HEREBY CERTIFY, That I attended deceased from *Nov 20 1937 to Nov 24 1937*I last saw *her* alive on *Nov 20 1937*. Death is saidto have occurred on the date stated above, at *9 P. M.*

The principal cause of death and related causes of importance were as follows:

Meningitis following ear infection Date of onset _____

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify _____

(Signed) *J. C. Caldwell* M. D.(Address) *Palmer Mo*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

10-3-25-35

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED EXCEPT WHERE SHOWN OTHERWISE
DATE 11/11/01 BY 60322 UCBAW/STP

12/14/41

UNCLASSIFIED

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42773
Do not use this space.

1. PLACE OF DEATH

(a) County Washington Registration District No. 908
 (b) Township Harrison Primary Registration District No. 6184 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Crowe W. Parmel

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 24 1937

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

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
24 1 21

Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Top Miner
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation _____ Date of _____

13. NAME

What test confirmed diagnosis? _____ Was there an autopsy? _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____.

15. MAIDEN NAME

Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Manner of injury _____

17. INFORMANT (ADDRESS)

Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

24. Was disease or injury in any way related to occupation of deceased? _____

19. FUNERAL DIRECTOR (ADDRESS)

If so, specify (Signed) A. J. Gresswell, M. D.

20. FILED Dec 14 1939 Mattie Turner Local Registrar

(Address) Palosi

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 COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

