

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.

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

4189
Do not use this space.

FEB 16 1938

1. PLACE OF DEATH

(a) County St. Louis
(b) Township Carondelet
(c) City.....
(d) Street No. 3617 Paule
(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.

Registration District No. 96
Primary Registration District No. 2
(If death occurred in Hospital or Institution, write its name instead of street and number)

Registered No. 229

2. PRINT FULL NAME Maude Parr 600

(a) Residence, No. 3617 Paule 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

3. SEX female 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 Harvey Parr

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 1, 1888

7. AGE YEARS 49 MONTHS 4 DAYS 1 If LESS than 1 day, hrs. or min.

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

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

FATHER 13. NAME Robert Brown

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Harvey C. Parr
(ADDRESS) 3617 Paule

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Hope DATE Feb 5/38

19. FUNERAL DIRECTOR Fendler Undertaking Co.
(ADDRESS) 7420 Michigan Ave.

20. FILED 23 1938 J. R. Myers Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 7 1938

22. I HEREBY CERTIFY That I attended deceased from Jan 27 1938 to Feb 2 1938. I last saw her alive on Feb 2 1938. Death is said to have occurred on the date stated above, at 2:15 P. m.

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

Lobar pneumonia Date of onset Jan 27

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?
If so, specify Waldorff Hill M. D.
(Signed) L. R. Myers (Address) Linnway R. 8 Mo.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)