

K. 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

4544
 Do not use this space.

1939 MAR 13 1939

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 or of **St. Louis**
 (c) City..... (d) Street No.: **1421 Park Avenue**..... 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
 (a) Residence, No. **1421 Park Avenue** SL 23 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb. 25, 1930**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	8	11	3	

OCCUPATION: 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **School child**
 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 **Joseph Parker**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

MOTHER
 15. MAIDEN NAME **Dell Reese**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

17. INFORMANT **Joseph Parker**
 (ADDRESS) **1421 Park Avenue**

18. BURIAL, CREMATION OR REMOVAL to **to**
 PLACE **Greeley, Mo.** DATE **1/30/39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **A. W. McLaughlin**
2301 Lafayette Avenue

20. FILED **FEB 8 1939** **J. B. Brubaker**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 28 1939**

22. I HEREBY CERTIFY That I attended deceased from **Jan 17 1939** to **Jan 28 1939**
 Last saw him alive on **Jan 27 1939** Death is said to have occurred on the date stated above, at **920 A**
 The principal cause of death and related causes of importance were as follows:
Acute Endocarditis
(following Acute Rheumatism)

Date of onset **Sept 1928**

Other contributory causes of importance: **Sarcoma Liver** **Sept 1928**

Name of operation **None** Date of.....
 What test confirmed diagnosis? **Heart specimen** Was there an autopsy? **no**

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.....
 (Signed) **W. S. Sausbury** M. D.
 (Address) **3058 - Lafayette**

1237

1237

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Me

....., Registered Apprentice No.

working under my personal supervision.

Signed

Paul A Keith

Licensed Embalmer No.

3612

P. O. Address

2317 Lafayette

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.)

If this body is not embalmed, above space should be left blank.

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

4544-39
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
 (b) Township..... Primary Registration District No. 1003 Registered No. 1237
 or
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

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

Wilma Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)			
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)					
7. AGE	YEARS	MONTHS	DAYS	If LESS than day, hr. or min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.				
	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)					
FATHER	13. NAME				
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
MOTHER	15. MAIDEN NAME				
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
17. INFORMANT (ADDRESS)					
18. BURIAL, CREMATION, OR REMOVAL					
PLACE DATE 19					
19. FUNERAL DIRECTOR (NAME) (ADDRESS)					
20. FILED 5-18 1939 <i>J. J. Bradeck</i> Local Registrar					

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 28 1939*

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:

Date of onset
Sept. 1936

Other contributory causes of importance: *Sept. 1936*

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.
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed)....., M. D.
 (Address).....

SUPPLEMENTARY

SUPPLEMENTARY

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.

S-4544

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.