

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

6050
Do not use this space.

REC'D MAR 15 1939

1. PLACE OF DEATH

(a) County Caldwell 2 Registration District No. 98
(b) Township Kingston 1 Primary Registration District No. 4060 Registered No. 5
(c) City Kingston (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred 43 yrs. — mos. — ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Charles Edwin Parker
(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

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 17 - 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
88 2 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
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) Carroll County Mo.

FATHER 13. NAME Willard Parker 0

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England 1/2

MOTHER 15. MAIDEN NAME Melinda Smith 1/2

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

17. INFORMANT (ADDRESS) W. H. Parker
Carter City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Kingston Cemetery DATE 2-18-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. Cramer Clark
Kingston Mo.

20. FILED Feb 16 1939 Mrs Ruth Hill
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 15, 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 7:00 A. m.

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

Myocardial degeneration Date of onset ?

Other contributory causes of importance: 920

Asthenia - SCD - etc.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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? No

If so, specify _____

(Signed) L. M. Daley (Coroner) M. D.

(Address) Haverhill, Calcd. Co.

RECEIVED

District Health Officer No. 197

District File Number 38-42

Date Filed 3/8/39

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,

Cramer Clark

, or by

Registered Apprentice No., working under my personal supervision.

Signed

Cramer Clark

Licensed Embalmer No.

3257

P. O. Address

Kingston Mo.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

6050
Do not use this space.

1. PLACE OF DEATH

(a) County Caldwell Registration District No. 98
(b) Township Primary Registration District No. 4060 Registered No.
(c) City Kennett (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

Chas Edwin Parker
(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 (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-15-1939

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

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.

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
88 2 28

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.....

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.....

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Feb 16 1939 McRute Hill Local Registrar.

RECEIVERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DECLARATION

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

