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.

REC'D AUG 12 1939

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

26106
Do not use this space.

1. PLACE OF DEATH
(a) County Lawrence
(b) Township Mt Vernon, Sol
(c) City ~~Mt Vernon, R 3~~
(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.

Registration District No. 470
Primary Registration District No. 5-633
Registered No. 92

2. PRINT FULL NAME 626 Infant Daughter of Mark & Grace 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S —
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: X
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 6th 1939
7. AGE: YEARS X; MONTHS X; DAYS X; If LESS than 1 day, ... hrs. or 15 min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mt Vernon Mo

FATHER
13. NAME: Mark Parker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Christian Co Mo

MOTHER
15. MAIDEN NAME: Grace Carney
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lawrence Co Mo

17. INFORMANT (ADDRESS): Mark Parker Mt Vernon Mo

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Camp Ground DATE July 7th 1939

19. FUNERAL DIRECTOR (NAME) Chesapeake Mo Lawrence Co
(ADDRESS) Geo B Orr

20. FILED July 31 1939 P. A. Holmes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 6th 1939

22. I HEREBY CERTIFY, That I attended deceased from July 6, 1939 to July 6, 1939
I last saw her alive on July 6, 1939 Death is said to have occurred on the date stated above, at 6 P.M.
The principal cause of death and related causes of importance were as follows:

Inanition due to the condition of mother which was anaemia valvular heart condition and high blood pressure which condition continued through out gestation.

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? 158 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 .....
(Signed) Mill Smith, M. D.
(Address) 121 W Pleasant Avenue Mo

Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 839-1548
Date Filed AUG 8 1939

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 com with the above constitutes grounds for revocation of license.)

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