

Registration District No. **791**

Primary Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Phillips Hospital**
(If not in hospital or institution, write street number or location) **/**
(d) Length of stay: In hospital or institution **4 days** (Specify whether
In this community **11 years**
years, months or days)

8. (a) PRINT FULL NAME **WILLIE PARKER**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Stella Parker** 6. (c) Age of husband or wife if alive **37** years

7. Birth date of deceased. **Aug 19 1906**
(Month) (Day) (Year)

8. AGE: Years **34** Months **0** Days **29** If less than one day hr. _____ min. _____

9. Birthplace **Ark.** (City, town, or county) (State or foreign country)

10. Usual occupation **laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Newry Parker** 13. Birthplace **Texas**
14. Maiden name **Newry Butler** 15. Birthplace **Texas**

16. (a) Informant **Cassell Parker** (b) Address **3117 Vinegrove**

17. (a) **St. Louis Ill** (b) Date thereof **Sept. 22-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Backus Washington**

18. (a) Signature of funeral director **W. C. Howard**

(b) Address **St. Louis Ill**

19. (a) **SEP 20 1940** (b) **J. B. [Signature]**
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St Louis** **10**
(If outside city or town limits, write "RURAL")
(d) Street No. **3117 Vinegrove**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **18**
year **1940** hour **12:30** minute _____ A.M.

21. I hereby certify that I attended the deceased from **Sept 14**, 19**40**, to **Sept 18**, 19**40**, that I last saw him alive on **Sept 18**, 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Osteomyelitis**
Lt Frontal Sinus
Cavernous Sinus Thrombosis

Duration
1 year
2 days

Due to _____

Due to **Non Tubercular**

Other conditions: (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **gzb**
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury **/**

23. Signature **W. C. Howard** (M. D. or other) _____
Address **2601 N Whittier** Date signed _____

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.....

A. E. Jones

..... Licensed Embalmer No. *3518*

..... P. O. Address *East Point Ga*

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.