

FILED DEC 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39637

Registration District No. 771

Primary Registration District No. 6077

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Iron Mountain Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois

(c) City or town Iron Mountain Mo. Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Billy Allen Parker.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 5

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 27 1929
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 23rd
year 1940 hour 1:30 minute A M.

21. I hereby certify that I attended the deceased from Nov-19th
1940, to Nov-22 1940.

that I last saw him alive on Nov-22 1940,
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>1</u>	<u>-</u>	<u>26</u>	hr. min.

9. Birthplace Iron Mountain Mo
(City, town, or county) (State or foreign country)

Immediate cause of death _____

Due to Pneumonia

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name Clifford Parker

13. Birthplace Reynolds Co. Mo
(City, town, or county) (State or foreign country)

14. Maiden name Martha Short

15. Birthplace Howes Mill Mo
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature C. Parker

(b) Address Iron Mountain Mo

17. (a) Burial (b) Date thereof Nov 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Howes Mill Mo

18. (a) Signature of funeral director W. H. White

(b) Address Iron Mountain Mo

19. (a) Nov 23 1940 (b) F. H. Gale
(Date received local registrar) (Registrar's signature)

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 F. H. Gale, M.D. (M. D. or other) _____

Address Desmarche Mo Date signed 11/23/40

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.

107W

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 the above constitutes grounds for revocation of license.)

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

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Registration District No. 771

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Registrar's No.

1. PLACE OF DEATH:

(a) County: St. Francois
(b) City or town: Donn
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME: Billy Allen Parker

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex: m 5. Color or race: w 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 26 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits write "RURAL.")

(d) Street No..... (If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month Nov day 28 year 1940 hour..... minute..... M.

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

Immediate cause of death: Double Bronchitis
Pneumonia
Due to: No Bron Complications

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

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: L. W. Gale (M. D. or other)

Address: Sumner, Mo Date: Nov 29 40

SUPPLEMENTARY

MOTHER FATHER

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

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

1940

S-39637