S. No. 2
4-13-40

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 31 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3006

Registration District No. 1003 — Primary Registration District No. 5799 — Registrar's No.

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

1. PLACE OF DEATH:
(a) County: New Madrid
(b) City or town: Rural Wheat Twp
(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 years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: New Madrid
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 5 miles S. East of Sikeston
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Juevada Parker
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex: F 1
5. Color or race: W
6. (a) Single, widowed, married, divorced: U
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Sept. (Month) 28 (Day) 1941 (Year)
8. AGE: Years ____ Months 2 Days 13 If less than one day ____ hr. ____ min.
9. Birthplace: Sikeston (City, town, or county) Mo. (State or foreign country) U
10. Usual occupation ____
11. Industry or business ____
MOTHER FATHER
12. Name: James H. Parker
13. Birthplace: East Prairie (City, town, or county) Mo (State or foreign country) U
14. Maiden name: Mildred Lucille Moore
15. Birthplace: Malden (City, town, or county) Mo. (State or foreign country) U
16. (a) Informant: James H. Parker
(b) Address: Sikeston Mo. R.F.D# 3
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/12/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Bertrand Mo. R.F.D
18. (a) Signature of funeral director: Hunter Allcutten
(b) Address: Sikeston Mo.
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 11 year 1941 hour 3 minute a M.
21. I hereby certify that I attended the deceased from Oct 28-30, 1941, to Dec. 11, 1941; that I last saw h alive on Nov 10-, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Blood stream infection	
Due to: Influenza + pneumonia infection of ear	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 330	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — 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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature: A. A. Mayfield (M. D. or other)
Address: Sikeston Mo. Date signed 11-11-41

100 (Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sikeston 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, fact should be so stated above.

No. 2B
M -d-21-41
1 X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3006

Registration District No. 603 Primary Registration District No. 5799 Registrar's No.

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town 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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Juevada Parker
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 28 1941 (Month) (Day) (Year)

8. AGE: Years | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) May 25/42 (Date received by local registrar) (b) Mae Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY