PARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 19 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

25449

State File No.

Registration District No. 833

Primary Registration District No. 3074

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Scott

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

(c) Name of hospital or institution: Sikeston General Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 103

(a) State Missouri (b) County Stoddard 0

(c) City or town Rural (If outside city or town limits, write "RURAL") 0

(d) Street No. 3 miles W. Canalou, Mo. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME Dallas Eugene Parker

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 0 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 24 (Day) 1942 (Year)

8. AGE: Years 0 Months 0 Days 4 If less than one day hr. min.

9. Birthplace Sikeston, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Eugene Parker
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Marjorie Miller
15. Birthplace Kewanee, Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant Eithel Miller

(b) Address Canalou, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-42 (Month) (Day) (Year)

(c) Place: burial or cremation Essex, Mo.

18. (a) Signature of funeral director John Albritton

(b) Address Sikeston, Mo.

19. (a) 8-14-42 (Date received local registrar) (b) H B Throgmorton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1942 hour 3 minute P.M.

21. I hereby certify that I attended the deceased from 7-28-, 1942 to 7-28, 1942 that I last saw him alive on 7-28, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Bronchopneumonia

Duration 16 hours

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) none

Major findings:
Of operations none
Of autopsy none

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) none

(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 M G Anderson (M. D. or other)

Address Sikeston Date signed 8-12-42

1039

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 842-1069
Date Filed 8-17-42

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 Allin

Body not Embalmed

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 compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
21-41
29288

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. 25449

Registration District No. 333 Primary Registration District No. 3074 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(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 (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 Dallas Eugene 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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 24 (Day) 1902 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day hr. min.

9. Birthplace (City, town, or county) no (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)

MOTHER FATHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from B
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 Bilateral Bronchopneumonia	16 hrs
Due to	
Due to	
Other conditions none (Include pregnancy within 3 months of death)	

107

Major findings:
Of operations no
Of autopsy no

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) none
(b) Date of occurrence no
(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. G. Anderson (M. D. or other)
Address Sikeston Mo Date signed 9-1-42