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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35597

State File No. \_\_\_\_\_

FILED NOV 10 1943

Registration District No. 1943

Primary Registration District No. 3058

Registrar's No. 172

1. PLACE OF DEATH:

(a) County S. Charles  
(b) City or town S. Charles  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
709 Clark Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Lifetime  
years, months or days)

3. (a) PRINT FULL NAME Mary Jane Parsons  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Andrew Parsons  
6. (c) Age of husband or wife if alive Edward years  
7. Birth date of deceased October 9 1848  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
95 0 3 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Thomas D. Ellis  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Moss  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Muslie Taqq  
(b) Address S. Charles, Mo  
17. (a) Burial (b) Date thereof Oct. 15-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Masidona Center Ball Street  
18. (a) Signature of funeral director N.C. Dallenberger & Sons  
(b) Address 201 N. Second, S. Charles, Mo  
19. (a) 10-13-1943 (b) Ernest C. Parke  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County S. Charles  
(c) City or town S. Charles  
(If outside city or town limits, write "RURAL")  
(d) Street No. 709 Clark Street  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12  
year 1943 hour 12 minute 30 P. M.  
21. I hereby certify that I attended the deceased from Sept 29  
1943 to Oct 12 19 43  
that I last saw her alive on Oct 12 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema Duration 24 hrs.  
Due to Senility  
fracture left hip -  
Due to fracture of femur 14 da  
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) 1571  
(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 Vernon C. Johnson (M. D. or other) MD  
Address S. Charles, Mo Date signed 10/14/43

REPRODUCING BLACK INK—MAKE A PERMANENT RECORD

1340

(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.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*John E. Dallmeyer*

Licensed Embalmer No. *2951*

P. O. Address *St Charles 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

1100V

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town St. Charles  
(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 Life years, months or days) (Specify whether

3. (a) PRINT FULL NAME Mary Jane Parsons  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 9  
(Month) (Day) (Year)

8. AGE: Years 95 Months 0 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day 12 Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

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

Immediate cause of death Pulmonary Edema  
fracture chest hip

Due to fracture of femur 14 da.

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) Accident

(b) Date of occurrence Sept 28 - 1943

(c) Where did injury occur? Home, Winfield, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Fall

23. Signature Wesley C. Schindler (M. D. or other) MD  
Address St. Charles, Mo. Date signed 11/3/43

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

SUPPLEMENTARY

Duration 2 1/2 hr  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

FILED

35597