

FILED FEB 14 1944
Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **322**

1. PLACE OF DEATH:

(a) County **Saint Louis**
(b) City or town **Jefferson Barracks**
(c) Name of hospital or institution: **STATION HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Forty-six days**
In this community **About Three months**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Florida** (b) County **Unknown**
(c) City or town **Tampa**
(If outside city or town limits, write "RURAL")
(d) Street No. **104 South Moody Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **-----**

3. (a) PRINT FULL NAME **ROY O PARODIE**

3. (b) If veteran, name war **World War II** 3. (c) Social Security No. **Unknown**

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

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

7. Birth date of deceased **November 30 1922**
(Month) (Day) (Year)

8. AGE: Years **21** Months **2** Days **6** If less than one day **--- hr. --- min.**

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

10. Usual occupation **Soldier (Private)**

11. Industry or business **United States Army**

12. Name **Unknown**

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

14. Maiden name **Siva (Last name unknown)**

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

16. (a) Informant **Service and Clinical Records**

(b) Address **Sta Hosp, Jefferson Bks, Mo.**

17. (a) **General** (b) Date thereof **2-9-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Tampa Fla**

18. (a) Signature of funeral director **Frank Albarran**

(b) Address **Keokuk Mo**

19. (a) **FEB 8 1944** (b) **E. S. ...**
(Date of burial) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **Sixth**
year **1944** hour **8:37** minute **A** M.

21. I hereby certify that I attended the deceased from **December 23 1943** to **February 6 1944**
that I last saw him alive on **February 6 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Rheumatic Fever, acute and Pericarditis and Valvular Heart Disease, Mitral Insufficiency**
Due to **Pneumonia, Lobar, acute, left lower & Right Lower & Middle Lobes, Type VII**
~~xxx~~ **Pneumococci**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **108**
Of autopsy **Confirmed above**

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)

23. Signature of physician **WILLIAM G BERNHARD, Maj, MC (M. D. or other) MD**
Address **Sta Hosp, Jefferson Bks, Mo** Date **7 Feb 1944**

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.....

Felix Girard

Licensed Embalmer No.....

30 34

P. O. Address.....

Kirtwood, Mo.

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, fact should be so stated above.