

FILED MAR 14 1944

Registration District No. 7

Primary Registration District No. 3016

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

1. PLACE OF DEATH:

(a) County COLE

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

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 DAYS
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME NORMA HESTER PARRISH

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MALCOM PARRISH

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

7. Birth date of deceased APRIL 21 1922
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>10</u>	<u>4</u>	hr. _____ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER { 12. Name STANLEY BROCKMAN

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

14. Maiden name ERSULA BLAUNT

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

16. (a) Informant MALCOM PARRISH

(b) Address Eldon, Missouri

17. (a) BURIAL (b) Date thereof 2 27 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TUSCUMBIA CEMETARY

18. (a) Signature of funeral director Phillips Funeral Home

(b) Address Eldon, Missouri

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 66

(a) State MISSOURI (b) County MILLER

(c) City or town Eldon
(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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 26
year 1944 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb. 20, 1944, to Feb. 25, 1944, that I last saw her alive on Feb. 25, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death
Bilateral Pneumonitis
(Post-operative) 5 days

Due to Caesarean Section for
contracted Pelvis 2-20-44

Due to Sec anemia (Lues)

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

Duration

PHYSICIAN

Major findings: _____

Of operations: _____

Of autopsy: none

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

23. Signature W. Osman (M. D. or other) M.D.

Address Jefferson City, Mo. Date signed 2/28/44

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 3-13-44

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 _____

working under my personal supervision.

Louis D Phillips

Registered Apprentice No. _____

Signed _____

Louis D Phillips

Licensed Embalmer No. 3663

P. O. Address _____

Edison

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.

Registration District No. 77 Primary Registration District No. 3016

1. PLACE OF DEATH:

(a) County Cal
(b) City or town Jefferson city
(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

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.....

In this community..... years, months or days)
3. (a) PRINT FULL NAME Mrs. Norma Richter Pappert
Norma H. Richter

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 1944 year 1944 hour 5:30 minute 30 M.
21. I hereby certify that I attended the deceased from 1944 to 1944;
that I last saw him alive on 7/30/44, 1944;
and that death occurred on the date and hour stated above.
Immediate cause of death.....

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 m

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

7. Birth date of deceased April 21 (Month) (Day) (Year)

8. AGE: Years 21 Months 10 Days 10 Unless than one day..... min.

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

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) 2-25-44 (b) Norma Richter (Date received local registrar) (Registrar's signature)

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

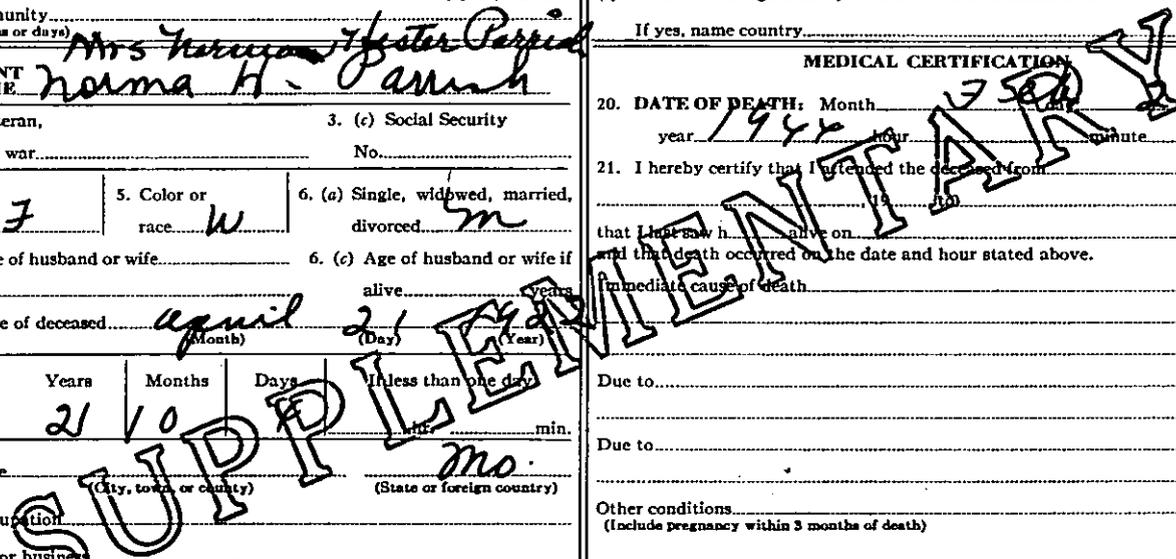
Duration

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?
While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature..... (M. D. or other)
Date signed.....

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



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