

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21507**  
Registrar's No. **75**

FILED JUL 13 1944  
Registration District No. **1108**

Primary Registration District No. **4197**

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

**1. PLACE OF DEATH:**  
(a) County Henry  
(b) City or town Stanhurst  
(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 40 years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State MO (b) County Henry 38  
(c) City or town Stanhurst (If outside city or town limits, write "RURAL")  
(d) Street No. Willow End Main St 3 (If rural, give location)  
(e) Citizen of foreign country? NY (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Mr. Frank A. Parker  
**3. (b) If veteran,** ✓ name war \_\_\_\_\_  
**3. (c) Social Security No.** None

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month June day 23<sup>rd</sup>  
year 1944 hour 4 minute 9 M.  
**21. I hereby certify that I attended the deceased from** May 10  
1944 to June 23, 1944  
that I last saw h. in alive on June 20, 1944  
and that death occurred on the date and hour stated above.

**4. Sex** Male **5. Color or race** W  
**6. (a) Single, widowed, married, divorced, or married** married  
**6. (b) Name of husband or wife** Mrs. Kittie C. Parker  
**6. (c) Age of husband or wife if alive** 71 years  
**7. Birth date of deceased** Feb 14, 1873  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage  
Duration \_\_\_\_\_

**8. AGE:** Years 72 Months 3 Days 29  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

**9. Birthplace** Henry Co. MO (City, town, or county) (State or foreign country)  
**10. Usual occupation** Retired Banker

**11. Industry or business** \_\_\_\_\_  
**12. Name** Stephen Parker  
**13. Birthplace** Mo. 9 (City, town, or county) (State or foreign country)  
**14. Maiden name** Mary E. Gagnier  
**15. Birthplace** Indiana (City, town, or county) (State or foreign country)

**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) (y) Means of injury \_\_\_\_\_

**16. (a) Informant** Mrs. Kittie C. Parker  
**(b) Address** Stanhurst, MO  
**17. (a) Burial (b) Date thereof 6-26-44  
(Burial, cremation, or other) (Month) (Day) (Year)  
**(c) Place: burial or cremation** Congreg. Church  
**18. (a) Signature of funeral director** Edwin H. Phillips  
**(b) Address** Stanhurst, MO  
**19. (a) July 1-1944** (b) Edwin H. Phillips  
(Date received local registrar) (Registrar's signature)**

**23. Signature** J. E. Simpson (M. D. or other) \_\_\_\_\_  
**Address** Stanhurst, MO **Date signed** 6-23-44

1108

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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

*Lester H. Phillips*

Licensed Embalmer No.

*1898*

P. O. Address

*Staten Island NY*

**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.