. S. No. 2
0M—5-43
v. 5-17-39
1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 39684

Registrar's No. 11342

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether

In this community Life 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")

(d) Street No. 4253 W. Maffitt
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sam Parish

3. (b) If veteran, name war

3. (c) Social Security No. 497-05-5617

4. Sex Male

5. Color or race Col

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

6. (b) Name of husband or wife Fontine Parrish

6. (c) Age of ~~husband~~ or wife if alive 45 years

7. Birth date of deceased June (Month) 1d (Day) 1892 (Year)

8. AGE: Years 52 Months 6 Days 18. If less than one day hr. min.

9. Birthplace St Louis. (City, town, or county) Mo (State or foreign country)

10. Usual occupation LABOR.

11. Industry or business

FATHER
12. Name SAM. HOUSTON. PARRISH.
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name EMMA HICKS.
15. Birthplace St Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant MRS. FORSTINE PARRISH
(b) Address 4217 Maffitt

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 5 1945 (Month) (Day) (Year)
(c) Place: burial or cremation GREENWOOD CEMETERY

18. (a) Signature of funeral director HERMAN J. SMITH.
(b) Address 4247 LABADIE AVE

19. (a) JAN 4 1945 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 31, year 1944 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from December 26, 1944 to December 31, 1944; that I last saw him alive on December 31, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Far advanced Pulmonary Tuberculosis	Unknown
Due to	
Due to	
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)

(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 Alva Moore (M. D.)

Address 2601 Whittier Date signed 1/2/45

(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 William C. McDowell, Registered Apprentice No._____, working under my personal supervision.

Signed. William C. McDowell

Licensed Embalmer No. 2114

P. O. Address_____

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.