

No. 2
9-4-41
5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 7 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6008**
Registrar's No. **12**

Registration District No. **100**

Primary Registration District No. **3012**

1. PLACE OF DEATH

(a) County **Dent**
(b) City or town **Salem**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **65 years** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dent** **33**
(c) City or town **Salem, Mo.** **1**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **1**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **0**

3. (a) PRINT FULL NAME

Rachel Parker

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 **S. D**

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

7. Birth date of deceased **April 7 1867**
(Month) (Day) (Year)

8. AGE: Years **77** Months **10** Days **5**
If less than one day _____ hr. _____ min.

9. Birthplace **Reynolds Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business _____

MOTHER FATHER { 12. Name **Nathaniel V. Parker**

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

14. Maiden name **Elizabeth Adams**

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

16. (a) Informant **Pearl Parker**

(b) Address **St Louis, Mo.**

17. (a) **Burial** (b) Date thereof **2-14-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cedar Grove**

18. (a) Signature of funeral director **Robert S. Hartman**

(b) Address **Salem, Mo.**

19. (a) **2-13-45** (b) **Geo. D. McDaniel**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **12** X
year **1945** hour **8** minute **00** P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____,
that I last saw h_____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **anemic** **2 days**
Duration

Due to **Dehydration**

Due to **Vomiting from injury** **no week**

Other conditions (Include pregnancy within 6 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) **V.I. 33**

(b) Date of occurrence **2-12-45**

(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 **MD.**

23. Signature **M. D. Hartman** (M. D. or other) **MD.**

Address **Salem, Mo.** Date signed **2/14/45**

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

1177

RECEIVED

District Health Officer No. 5

District File Number

345134

Date Filed

3-5-45

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.....

me

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Oral E. Licklider

Licensed Embalmer No.

3546

P. O. Address

St James m

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. 100

Primary Registration District No. 3018

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Salem
(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 years, months or days)

3. (a) PRINT FULL NAME Rachel Parker

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 S

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

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

8. AGE: Years 77 Months 10 Days 10 If less than one day min.

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

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 Feb Day 2
Year 1941 Hour 11 minute 2 M.

21. I hereby certify that I attended the deceased from 1941 to 1941

that I last saw him alive on 1941 and that death occurred on the date and hour stated above. Immediate cause of death

Duration
Had arisen in very early AM.

Due to Fell & struck frontal part of head on bedstead.

Other conditions (Include pregnancy within 3 months of death) 1860

Major findings: Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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) accident

(b) Date of occurrence 2-2-41

(c) Where did injury occur? SALEM DENT MO.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

While at work? (Specify type of place) (e) Means of injury Fell

23. Signature M. M. [Signature] (M. D. or other) MD

Address Date signed 2-5-41

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

SUPPLEMENTARY INFORMATION REQUESTED

0008