

FILED MAY 17 1945

Registration District No. **317**

Primary Registration District No. **3063**

Registrar's No. **1029**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day 4 hrs.**
(Specify whether Life
In this community **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Brentwood**
(If outside city or town limits, write "RURAL")
(d) Street No. **8770 Rose Avenue**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **22nd**
year **1945** hour **Three** minute **45** AM

21. I hereby certify that I attended the deceased from
April 20th, 19**45** to **April 22nd**, 19**45**
that I last saw h. **im** alive on **April 22nd**, 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death
Uremia
Duration
?

Due to **Chronic pyelo-nephritis** **14 mos.**

Due to
Other conditions
(Include pregnancy within 3 months of death)
1330

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 **John A. Wilson** (M. D. or other) **M.D.**
Address **St. Louis County Hospital** Date signed **4-22-45**

3. (a) PRINT FULL NAME **KING PARSONS**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **Male** 9
5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Lenora Boyd**
6. (c) Age of husband or wife if alive **34 yrs**

7. Birth date of deceased **December 12 1901**
(Month) (Day) (Year)

8. AGE: Years **43** Months **4** Days **10**
If less than one day hr. min.

9. Birthplace **Washington Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business **General Refractory Co.**

12. Name **Thomas Parsons**

13. Birthplace **-- unavailable --** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Alzonia ?**
-- unavailable -- **9**
(City, town, or county) (State or foreign country)

15. Birthplace **-- unavailable --** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lenora Parsons**

(b) Address **8770 Rose Ave., Brentwood**

17. (a) **Burial** (b) Date thereof **4-26-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Chas. J. Gates**

(b) Address **4107 Finney Ave.**

19. (a) **MAY 2 1945** (b) **E. G. McCarroll**
(Date received local health officer) (Registrar's signature)

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

26
2
3

310

17-45

MAY 19 1945

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.....

Thomas J. Gates

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

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.