S. No. 2
M—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1945

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

27409

State File No.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 688

**1. PLACE OF DEATH:**

(a) County GREENE

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

(c) Name of hospital or institution: 829- N- WEAVER 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 years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County GREENE

(c) City or town SPRINGFIELD (If outside city or town limits, write "RURAL")

(d) Street No. 829- N- WEAVER (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ALICE GERTRUDE PARKER

3. (b) If veteran, name war NONE

3. (c) Social Security No. UNK.

4. Sex Female 3 5. Color or race NEGRO

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

6. (b) Name of husband or wife Unk.

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

7. Birth date of deceased MARCH (Month) 17 (Day) 1891 (Year)

8. AGE: Years 54 Months 4 Days 14 If less than one day hr. min.

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

10. Usual occupation DOMESTIC

11. Industry or business

FATHER
12. Name JOHN THOMAS
13. Birthplace UNKNOWN (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name MARGARET BURNS
15. Birthplace UNKNOWN (City, town, or county) MO (State or foreign country)

16. (a) Informant MRS LUCILLE ADAMS

(b) Address 829- N- WEAVER - Spfd, Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept- 4- 1945 (Month) (Day) (Year)

(c) Place: burial or cremation HAZLEWOOD

18. (a) Signature of funeral director Herbert V Smith

(b) Address 702- N- Jefferson, Spfd, Mo

19. (a) 9-4-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 8- day 31 year 1945 hour 4 minute 00 P.M.

21. I hereby certify that I attended the deceased from May 29, 1945 to Aug. 30 1945 that I last saw her alive on Aug. 29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chr. hypertensive cardio vascular renal dis. with decompensation

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration 6 MO.

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 Arthur D Knapp (M.D. or other) M.D.

Address 450 1/2 S Cornell, Spfd, Mo Date signed 9-1-45

(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.....

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

working under my personal supervision.

Signed Herbert V. Smith

Licensed Embalmer No. 4286

P. O. Address Springfield Mo

**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.**

X