S. No. 2
DM—5-43
v. 5-17-39
p I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1005

State File No. 35709

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 10390

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution: Homer Phillips Hospital (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)

In this community 40 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 2713 Walnut st (If rural, give location) 9

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Callie Parker

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex F 3

5. Color or race Col

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept (Month) 23 (Day) 1878 (Year)

8. AGE: Years 67 Months 2 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER

12. Name George Johnson

13. Birthplace unk (City, town, or county) Mo (State or foreign country)

14. Maiden name Henrietta Williams

15. Birthplace unk (City, town, or county) Mo (State or foreign country)

16. (a) Informant Emmet Young

(b) Address 2729 Lawton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-45 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J H Randle & Son

(b) Address 3133 Bell Ave

19. (a) NOV 30 1945 (Date received local registrar) J H Reed (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24 year 1945 hour 11 minute 30 A.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 Fractured left femur

Due to Pulmonary Congestion Cardiac

Due to Apparently suffered while deceased fell on the sidewalk in front

Due to 2626 23 Walnut on Nov 9 1945 at about 3:30 P.M.

Other conditions (Include pregnancy within 3 months of death) NO

Major findings: Of operations NO

Of autopsy NO

Duration

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 Nov. 9 1945 000

(c) Where did injury occur? St Louis (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? _____ (e) Means of injury 3 above

23. Signature Gilmore E Taylor (M. D. or other)

Address Dry Ave Date signed 11/29/45

(Licensed Embalmer's Statement on Reverse Side)

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

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 Clark Young

Licensed Embalmer No. 3371

P. O. Address St. Louis

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.