

FILED FEB 1 1946 STANDARD CERTIFICATE OF DEATH

State File No. 761

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 775

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 G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Hrs. 13 Mins
(Specify whether

In this community _____
years, months or days)

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") 21/19

(d) Street No. 716 N. Garrison 9
(If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME Catherine Parker Twin #2

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced (1)

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

7. Birth date of deceased: 12 (Month) 27 (Day) 45 (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. 7 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name John Francis Parker

13. Birthplace Little Rock Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Terra Bell

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ether M. Sherard, R.R. 2

(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof 1-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson

(b) Address JAN 24 1946 City Health Dept

19. (a) _____ (b) J. F. Prebeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27
year 1946 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from 5:11 A.M.
12 - 27, 1945 to 11:15 A.M. 12-27-45
that I last saw her alive on 12 - 27, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

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

23. Signature W. H. Simkus (M. D. Registrar)
Address 2601 N. Whittier Date signed 12-27-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100804

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.....

Licensed Embalmer No.....

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.