

S. No. 2
-12-45
5-17-39
P 1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34632**
Registrar's No. **3066**

Registration District No. **317** Primary Registration District No. **3063**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Clayton**
(c) Name of hospital or institution:
St. Louis County Hospital
(d) Length of stay: In hospital or institution **5 days**
In this community **5 days**

3. (a) PRINT FULL NAME **Harold S. Parsonage**
3. (b) If veteran, name war **W.W. II**
3. (c) Social Security No. **497-09-9519**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Peggy Parsonage**
6. (c) Age of husband or wife if alive **25** years
7. Birth date of deceased **8-16-1919**

8. AGE: Years **27** Months **1** Days **29**
If less than one day hr. min.

9. Birthplace **West Frankfort, Ill.**

10. Usual occupation **electrician**

11. Industry or business **Daybright Lighting Inc.**

12. Name **Noble G. Parsonage**

13. Birthplace **England - England**

14. Maiden name **Edith Beech**

15. Birthplace **Liverpool - England**

16. (a) Informant **Mrs. Harold Parsonage**

(b) Address **1924 Bryant Overland**

17. (a) **Burial** (b) Date thereof **10-19-46**

(c) Place: burial or cremation **Oak Grove Cemetery**

18. (a) Signature of funeral director **C. R. Lipton & Sons**

(b) Address **7233 Dequay Blvd.**

19. (a) **10-17-46** (b) **W. Allen**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Overland**
(d) Street No. **1924 Bryant**
(e) Citizen of foreign country? **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **15** year **1946** hour **4** minute **15 P.M.**
21. I hereby certify that I attended the deceased from **10-10-1946** to **10-15-1946**
that I last saw him alive on **10-15-46** and that death occurred on the date and hour stated above.

Immediate cause of death **Poliomyelitis with encephalitic and bulbar involvement**

Due to **36**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **no lesions generalized hyperemia of entire CNS**
Of autopsy **see above**

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

While at work? (Specify type of place) (c) Means of injury
23. Signature **W. Allen** (M. D. or other) **MD**
Address **St. Louis County Hosp** Date signed **10-15-46**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

NOV 4 1946

NOV 1 1946

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 John Ketter
Licensed Embalmer No. 3880
P. O. Address St. Louis, 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.