

No. 2
-12-45
5-17-39
I. X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 9 1947

UNITED STATES DEPARTMENT OF HEALTH OF THE UNITED STATES
STANDARD CERTIFICATE OF DEATH

State File No. **19740**
Registrar's No. **1111**

Registration District No. **3** Primary Registration District No. **6076**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Robert Koch Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **69 days** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John Parker**
3. (b) If veteran, name war..... **3. (c) Social Security** No.....

4. Sex **M** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced, separated **Separated**
6. (b) Name of husband or wife **Wife** **6. (c) Age of husband or wife if alive** **Wife** years.....
7. Birth date of deceased **8** **17** **1888**
(Month) (Day) (Year)

8. AGE: Years **58** Months **9** Days **9** If less than one day hr. min.

9. Birthplace **Birmingham Ala**
(City, town, or county) (State or foreign country)

10. Usual occupation **Labourer**

11. Industry or business **Packing House**

12. Name **John Parker**

13. Birthplace **Ala**
(City, town, or county) (State or foreign country)

14. Maiden name **Edna Shepherd**

15. Birthplace **Ala**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert Koch Hospital**
(b) Address **Anatomical Board**

17. (a) **Anatomical Board** **(b) Date thereof** **5-27-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Northampton**

18. (a) Signature of funeral director **W. R. R. R.**

(b) Address **JUN 2 3555 Bessie St**

19. (a) **JUN 2** **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **000**
(c) City or town **St. Louis** **9**
(If outside city or town limits, write "RURAL")
(d) Street No. **1627 Franklin** **1**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **26**
year **1947** hour **10** minute **30A** M.
21. I hereby certify that I attended the deceased from **3-18** 19**47**, to **5-26** 19**47**
that I last saw him alive on **5-26** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis** **by?**
Duration

Due to **138**

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

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?

23. Signature **William B. Moore** (M. D. or other) **M.D.**
Address **Robert Koch Hospital** Date signed **5-27-47**
While at work (Specify type of place) (e) Means of injury **0**

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

MOTHER FATHER

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.