

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 1 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44809

State File No.

Registration District No. 237

Primary Registration District No. 4353

Registrar's No. 9

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Gideon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 2 days (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Gideon 72
(If outside city or town limits, write "RURAL") 100
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ELMER ELEN PARKER

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive Child years
7. Birth date of deceased Sept. 16 1947
(Month) (Day) (Year)

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

9. Birthplace _____ (City, town, or country) (State or foreign country) 96

10. Usual occupation Child

11. Industry or business _____

12. Name Elmer Parker Sr.

13. Birthplace Magnolia Miss (City, town, or country) (State or foreign country)

14. Maiden name Conway (City, town, or country) (State or foreign country)

15. Birthplace Arkansas (City, town, or country) (State or foreign country)

16. (a) Informant Elmer Baker

(b) Address Gideon, Missouri

17. (a) Burial (b) Date thereof 9-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanfield

18. (a) Signature of funeral director F. J. Russell

(b) Address St. Louis, Mo.

19. (a) May 18, 1948 (Date received local permit) Mrs. Byron Clay (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18
year 1947 hour 6 minute 5 P.M.
21. I hereby certify that I attended the deceased from 9-16-47
19____, to 9-18-47 19____;
that I last saw him alive on 9-18-47 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cranial Injury
Respiratory Failure
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)
Means of injury _____

23. Signature J. H. Hopkins (M. D. or other)
Address Gideon, Mo. Date signed 9-18-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 348-699

Date Filled 5-22-48

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.