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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 14 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **38523**
Registrar's No. **10489**

Registration District No. **318**

Primary Registration District No. _____

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

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 2 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ernestine Dixon Parnell
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Female 3. Color or race Col
5. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Lawrence
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased: June 8 1922
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
26 5 21 hr. min.

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

10. Usual occupation Unknown

11. Industry or business Housewife

12. Name Unknown

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

14. Maiden name Mattie Kale
(City, town, or county) (State or foreign country)

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

16. (a) Informant Josephine Kale

(b) Address 1011 North 2nd St

17. (a) None (b) Date thereof 12-2-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo

18. (a) Signature of funeral director P. J. Boggs

(b) Address 3847 Page Blvd.

19. (a) DEC 2 1948 (b) J. B. Sabatani
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2846 Franklin
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29
year 1948 hour 11 minute 20 a.m.
21. I hereby certify that I attended the deceased from Nov. 27 1948 to Nov. 29 1948
that I last saw h. er alive on Nov. 29 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Glomerulonephritis; Hypertension
Duration Undet.

Due to _____
Due to _____

Other conditions Probable Sub-acute Bacterial Endocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy None

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? _____

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

23. Signature Oscar J. Daniels (M. D. or other)
Address 2601 N. Whittier Date signed 11/30/48

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.....

O. J. Nash

Licensed Embalmer No. *2432*

P. O. Address *3849 Page Blvd.*

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.