

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25173  
6840

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____				
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo				b. COUNTY JO		
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St Louis		7				
d. FULL NAME OF HOSPITAL OR INSTITUTION 1406 Madison				d. STREET ADDRESS (If rural, give location) 26 1406 Madison				J		
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) O		c. (Last) Parker		4. DATE OF DEATH (Month) (Day) (Year) 8-4-1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 11-13-1864		9. AGE (In years last birthday) 84		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Topeka, Kansas		12. CITIZENRY OF WHAT COUNTRY? USA				
13a. FATHER'S NAME George Parker			13b. MOTHER'S MAIDEN NAME Malhilda ?			14. NAME OF HUSBAND OR WIFE Alice				
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Alice Parker			ADDRESS 1406 Madison St			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE CARDIAC DILATATION						INTERVAL BETWEEN ONSET AND DEATH 1 DAY		
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CHRONIC CARDIAC VALVULAR DISEASE						2 YEARS		
		DUE TO (c) SENILITY ARTERIOSCLEROSIS.						2 YEARS		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) ST. LOUIS MO						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 9:15 AM LIFTED						
22. I hereby certify that I attended the deceased from June 1, 1947, to Aug 4, 1949 that I last saw the deceased alive on Aug 4, 1949, and that death occurred at 9:05 a.m., from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) Anthony A. Piekoriski M.D.				23b. ADDRESS 15252 Cass Ave				23c. DATE SIGNED 8-4-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-6-49		24c. NAME OF CEMETERY OR CREMATORY St Matthews		24d. LOCATION (City, town, or county) (State) St Louis Mo				
DATE REC'D BY LOCAL REG. AUG 6 1949		REGISTRAR'S SIGNATURE J. B. Sasater			25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc					

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

0789

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Howard A. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *St Louis 10*

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.