

FILED OCT 10 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32121

State File No. ....

|   |  |   |            |  |  |   |  |  |
|---|--|---|------------|--|--|---|--|--|
| BIRTH NO. ....  |  | REG. DIST. NO. <b>317</b>   |            | PRIMARY REG. DIST. NO. <b>3070</b>   |  | Registrar's No. <b>2300</b>   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. LOUIS</b>   |  |   |            | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS Co.</b> |  |   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <b>WEBSTER GROVES</b>  |  | c. LENGTH OF STAY (in this place)   |            | c. CITY (If outside corporate limits, write RURAL and give township) <b>WEBSTER GROVES</b>   |  | 4577  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>956 GREELEY AVE.</b>   |  |   |            | d. STREET ADDRESS (If rural, give location) <b>956 GREELEY AVE</b>   |  |   |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>SALLY PARMELEE</b>  |  |   | a. (First) |  |  | b. (Middle)   |  |  |
| 4. DATE OF DEATH <b>9-26-1950</b>   |  |   | (Month)    |  |  | (Day) (Year)  |  |  |
| 5. SEX <b>F</b>   |  | 6. COLOR OR RACE <b>W.</b>  |            | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>  |  | 8. DATE OF BIRTH <b>APR. 10 - 1977</b>  |  |  |
| 9. AGE (in years last birthday) <b>73</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>   |            | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>LEAVENWORTH KANSAS</b>   |  |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 13a. FATHER'S NAME <b>WILLIAM A. ROSE</b>   |            | 13b. MOTHER'S MAIDEN NAME <b>SARAH HUMPHREY</b>  |  | 14. NAME OF HUSBAND OR WIFE <b>IRYING B. PARMELEE</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.   |            | 17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Edwin L. Foster, 246. Gross Mo.</b>  |  |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>carcinomatous type unknown</b>                                 |            |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>199B</b>   |  |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |            |  |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |            |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |            | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)  |  |   |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |  | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                 |            | 21f. HOW DID INJURY OCCUR?   |  |   |  |  |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. |  |   |            |  |  |   |  |  |
| 23a. SIGNATURE <b>Herbert Romke</b> (Degree or title)<br>Local Registrar of Vital Statistics  |  |   |            | 23b. ADDRESS<br><b>651 South Brentwood Boulevard</b>   |  | 23c. DATE SIGNED  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>  |  | 24b. DATE <b>9-27-1950</b>  |            | 24c. NAME OF CEMETERY OR CREMATORY <b>MT. MUNCIE</b>   |  | 24d. LOCATION (City, town, or county) (State) <b>LEVANWORTH KANSAS</b>  |  |  |
| DATE REC'D BY LOCAL REG. <b>9-26-50</b>   |  | REGISTRAR'S SIGNATURE <b>H. Romke</b>   |            | 25. FUNERAL DIRECTOR'S SIGNATURE <b>PARKER ALDRICH FUNERAL HOME INC</b><br>ADDRESS <b>606 Aldrich East St</b>                                    |  |   |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

JUN 4 1952

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 *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Wester Groves*

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.