

S. No. 300
REV. 10-48
4000

1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41151**

XC 16208230
REG #104278

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2879

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) JEFFERSON BARRACKS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
c. LENGTH OF STAY (In this place) 79 DAYS		d. STREET ADDRESS (If rural, give location) 2609 COLE	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP			

3. NAME OF DECEASED (Type or Print) a. (First) ISADORE	b. (Middle)	c. (Last) PARKER	4. DATE OF DEATH (Month) (Day) (Year) 11-4-52
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5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 2-22-87	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 8 Days 13	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY WAGNER ELEC. CO.	11. BIRTHPLACE (City and State or Foreign Country) HIGGINSVILLE, MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME HARRY PARKER	13b. MOTHER'S MAIDEN NAME LIZA COOPER	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I	16. SOCIAL SECURITY NO. 490148650	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF. BRKS., MO.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 years
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____		
	DUE TO (c) 443X		
II. OTHER SIGNIFICANT CONDITIONS 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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 8-18-52, 19 , to 11-4-52, 19 , that I did see the deceased ~~and that death occurred at 11:00 P.M., from the causes and on the date stated above.~~

23a. SIGNATURE R. A. ALLEN	(Degree or title) MD.	23b. ADDRESS VAH JEFFERSON BARRACKS., MO.	23c. DATE SIGNED 11-6-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 11-10-52	24c. NAME OF CEMETERY OR CREMATORY NAT'L	24d. LOCATION (City, town, or county) (State) JEFF BRKS MO
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DATE REC'D BY LOCAL REG. 11-8-52	REGISTRAR'S SIGNATURE Herbert R. Dornbush	25. FUNERAL DIRECTOR'S SIGNATURE A. F. WALTON	ADDRESS 2707 STODDARD ST.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 3 1931

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldene

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.