

FILED SEP 20 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30031**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 55 PRIMARY REG. DIST. NO. 3011 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN <u>Carrollton</u>	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>Carrollton</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>206 E. Washington</u>		e. STREET ADDRESS (If rural, give location) <u>206 E. Washington</u>	

3. NAME OF DECEASED (Type or Print) <u>PEPPIE LOUISIA PARKER</u>	a. (First) <u>PEPPIE</u>	b. (Middle) <u>LOUISIA</u>	c. (Last) <u>PARKER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 13 1954</u>
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5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Feb. 4 1883</u>	9. AGE (in years last birthday) <u>71</u>	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Ray Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James A. Donaldson</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ida Finley</u>	14. NAME OF HUSBAND OR WIFE <u>James Parker</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>500-28-5324</u>	17. INFORMANT'S SIGNATURE OR NAME <u>James Parker</u>	18. ADDRESS <u>Carrollton Mo</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) II: OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>7 yrs</u>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331 X</u>	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) (Min)	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 Aug 20 1954 to Sept. 13, 1954, that I last saw the deceased alive on Sept. 12, 1954, and that death occurred at 8:45 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. Conrad H. Smith M.D.</u>	23b. ADDRESS <u>207 1/2 St. Carrollton, Mo</u>	23c. DATE SIGNED <u>9-13-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-15-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Carrollton Mo.</u>
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DATE REC'D BY LOCAL REG. <u>SEP 21 1954</u>	REGISTRAR'S SIGNATURE <u>Hyde H. Bridges</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley Gibson</u>	ADDRESS <u>Carrollton Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

SEP 2

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.....  
Signature of Student Embalmer

Signed..... *Ben W. Gibson*

Licensed Embalmer No. 296

P. O. Address *Carroll*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.