

FILED JUN 20 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20302

State File No. ....

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **4737**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>70 yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>D.O.A. City Hospital</b>		STREET ADDRESS (If rural, give location) <b>23 710a Soulard Street 22370</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>EFFIE</b> b. (Middle) <b>FRANCES</b> c. (Last) <b>PARCEL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 30, 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>January 28, 1880</b>
9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Goodwill Industry</b>	11. BIRTHPLACE (City and State or Foreign Country) / <b>Unknown Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Thomas Mulligan</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Timothy Parcel deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Mamie Peers 2414a S. 4th Street</b>
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) <b>Chronic Myocarditis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic nephritis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>  <b>1 month</b>
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 (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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4201</b>	
22. I hereby certify that I attended the deceased from <b>June 1, 1954</b> , to <b>May 18, 1955</b> , that I last saw the deceased alive on <b>May 18, 1955</b> , and that death occurred at <b>10:20 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>H. G. Moore M.D.</b>		23b. ADDRESS <b>917 - 5018</b>	23c. DATE SIGNED <b>5-31-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>June 3, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Mathew Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis MO</b>
DATE REC'D BY LOCAL REG. <b>MAY 31 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>SUEDMEYER &amp; SON'S 3934 N. 20th Street</b>	

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

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 *Melvin L. Kempf*

Licensed Embalmer No. *1702*

P. O. Address *3505 Cla  
St. Louis 20, Mo*

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.