

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10854**
Registrar's No. **2434**

BIRTH NO. **10580-57** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). b. STATE MISSOURI c. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 3 DAYS	c. CITY OR TOWN St. Louis		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 St. Louis Children's Hospital			e. STREET ADDRESS (If rural, give location) 224 1310 South 10th STREET		
3. NAME OF DECEASED (Type or Print) a. (First) DENNIS		b. (Middle) Ralph	c. (Last) PARRIS	4. DATE OF DEATH (Month) (Day) (Year) March 9 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JAN. 21. 1957	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 1 Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME Edward W. Parris		13b. MOTHER'S MAIDEN NAME ONEITA AUSTIN		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME JANE HENRICHSEN ADDRESS 500 S KING HIGHWAY		
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) meningitis			INTERVAL BETWEEN ONSET AND DEATH 4 days		
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. 340.3		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" 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)		21f. HOW DID INJURY OCCUR?
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"/>			
22. I hereby certify that I attended the deceased from 3/7 , 19 57 , to 3/9 , 19 57 , that I last saw the deceased alive on 3/9 , 19 57 , and that death occurred at 4:45 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Barbara Jones M.D.			23b. ADDRESS 500 S. KING HIGHWAY		23c. DATE SIGNED 3/9/57
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-11-57	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
DATE REC'D BY LOCAL REG. MAR 11 '57		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL-DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	

