

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011267
STATE FILE NUMBER
2-3969
Registrar

300
1-57
25
574
0

FILED APR 6 1959 Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If outside, give location) 8677 Arkansas	
3. NAME OF DECEASED (Type or print) Charles Parker		4. DATE OF DEATH Month Day Year 3-23-59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe maker		10b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg	11. BIRTHPLACE (City and state or country) Harrisburg Ill
13a. FATHER'S NAME Thomas Parker		13b. MOTHER'S MAIDEN NAME Margaret Helton	14. NAME OF HUSBAND OR WIFE Donna
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 488-01-9997	
17. INFORMANT Address 9430 Flora		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO (b) Respiratory paralysis DUE TO (c) Cerebral metastases, carcinoma	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Primary carcinoma Larynx	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 161X	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1958 to 3/23/59 and last saw ^{her} / _{him} alive on 3/23/59 Death occurred at 11:35 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Charles M.D. (Degree or title)		22b. ADDRESS 4952 Highland	
22c. DATE SIGNED 3/23/59		23. NAME OF CEMETERY OR CREMATORY Hazel Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-24-59	
24. FUNERAL DIRECTOR Dr. F. Home ADDRESS 9222 Lakeland		25. DATE RECD. BY LOCAL REG. MAR 24 '59	
26. REGISTRAR'S SIGNATURE Loan Smith		27. STATE M.D. S.P.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Samuel Stipanovic, Student Embalmer No. 578 working under my personal supervision.

Student Samuel Stipanovic
Signature of Student Embalmer

Signed al c Detsman

Licensed Embalmer No. 3428

P. O. Address

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.