

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011270
STATE FILE NUMBER
2 2153

MAR 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

300
1-57
38
34

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lemay 4000</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 HOSPITAL OF D.O.A. City Hospital</u>		Length of stay in lb	d. STREET ADDRESS <u>9329 S. Broadway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alger</u> Middle <u>George</u> Last <u>Parrott</u>			4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1918</u>	9. AGE (In years) <u>40</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 MRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brewery Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Anheuser-Busch Inc.</u>	11. BIRTHPLACE (City and state or country) <u>Jackson, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Albert Parrott</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Glass</u>	14. NAME OF HUSBAND OR WIFE <u>Sue Irmgard Parrott</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>111-2</u>	17. INFORMANT <u>Mrs. Sue I. Parrott</u> Address <u>9329 S. Broadway Lemay, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arterio-sclerotic heart disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2 months ago had acute subarachnoiditis</u>		DUE TO (c) <u>420.0</u>

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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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 _____
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21. I attended the deceased from 12-30-58 to 2-28-59 and last saw ^{her}him alive on 2-27-59
Death occurred at 3:25 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Sue I. Parrott</u> (Degree or title)	22b. ADDRESS <u>75 1/2 Lemay, Lemay, Mo.</u>	22c. DATE SIGNED <u>3-2-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>March 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Bks. Mo.</u>
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24. NAME, ADDRESS OF FUNERAL HOME <u>G. Hoffmeister Mortuaries 7814 S. Broadway</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 2 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Lenius C. Hoffmeister*

Licensed Embalmer No. *3871*.....

P. O. Address *7814 S. Broad*

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.