

HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019928

STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. 317

Primary Registration District No. 548

Registrar's No. 1432

300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ill.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEBSTER GROVES, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Chicago</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Glenwood Home &amp; Hospital 2 yrs.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Austin</b> Middle <b>H.</b> Last <b>PARKER</b>			4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/6/1870</b>	9. AGE (In years less birthday) <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JUDGE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>	11. BIRTHPLACE (City and state or country) <b>VT.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Albert Parker</b>		13b. MOTHER'S MAIDEN NAME <b>Jeanette Hadley</b>		14. NAME OF HUSBAND OR WIFE <b>Mary H. Parker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <b>No</b> (unknown)) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unk</b>	17. INFORMANT Address <b>Mrs. A.Keith. 4605 Lindell Blvd</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>generalized arterio sclerosis</b>					<b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): <b>bronchopneumonia, chronic brain syndrome</b>					<b>4 2 2 1</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 <b>Aug. 58</b> to <b>May 22-59</b> and last saw <b>him</b> alive on <b>May 22, 1959</b> Death occurred at <b>8:30 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Thomas T. Flynn</b> (Print or title)			22b. ADDRESS <b>1300 Grant Rd. Webster Groves, Mo.</b>		22c. DATE SIGNED <b>5-23-59</b>
23a. BURIAL, CREMATION, REMOVAL (if)		23b. DATE <b>5/23/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chicago, Illinois</b>
24. FUNERAL DIRECTOR <b>C.R. Lupton &amp; Sons; 7233 Delmar Blvd</b>			25. DATE RECD. BY LOCAL REG. <b>5-23-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>

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 *Clarence H. Murray*

Licensed Embalmer No. *4011*  
P. O. Address *St. Louis, 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.