

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS OCT 19 1959

59-037937

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 9188**

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, give TOWNSHIP only) OR TOWN <b>St Louis</b>		c. CITY OR TOWN <b>St Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Louis Little Rock Hosp Inc</b>		d. STREET ADDRESS (If outside, give location) <b>2626a California</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Darwin Edward Parsel</b>			4. DATE OF DEATH Month Day Year <b>Oct 4, 59</b>			
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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>2, 27, 05</b>	9. AGE (last birthday) <b>54</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Loco Fireman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>ARKANSAS</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>WILLIAM PARSEL</b>	13b. MOTHER'S MAIDEN NAME <b>DELLA CLYMER</b>	14. NAME OF HUSBAND OR WIFE <b>Myrtle PARSEL</b>
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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>488, 09, 3330</b>	17. INFORMANT <b>MYRTLE PARSEL CALIFORNIA</b>	Address <b>2626a</b>
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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) <b>Ruptured Ventricular Aneurysm</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
DUE TO (b) <b>MYOCARDIAL INFARCTION, ACUTE</b>		<b>2 weeks</b>
DUE TO (c) <b>Coronary artery thrombosis</b>		<b>2 weeks</b>

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 <b>9-19-59</b> to <b>Oct 4, 1959</b> and last saw <sup>her</sup> him alive on <b>Oct 3, 59</b> Death occurred at <b>7, 25 am</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>R. C. Truman, M.D.</b>	22b. ADDRESS <b>Mo Pac. Hospital 1755 So Grand</b>	22c. DATE SIGNED <b>10/5/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT. 7 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CONCORDIA CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>
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24. FUNERAL DIRECTOR <b>Thomas Lutz 2906 Georgia</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 6 '59</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Eless Province

Licensed Embalmer No. 3403

P. O. Address 2906 Javo

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.