

JRI DIVISION - OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003900

FILED VS. JAN 15 1960

Primary Registration District No. _____ Registrar's No. 2 45 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis,</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Alexian Brothers Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4215a Easton Ave.</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Albert</u> Last <u>Parnell</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>1,</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</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>1-24-1905</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William Parnell</u>			13b. MOTHER'S MAIDEN NAME <u>Annie Smith</u>			14. NAME OF HUSBAND OR WIFE <u>Estelle Parnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Ernest Parnell 4335 Maffitt Ave.</u>			
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>Cerebral Apoplexy with left hemiparesis and recurrence of apoplexy 11/60.</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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	
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.) <u>334x</u>			
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
21. I attended the deceased from <u>Dec 22 '59</u> to <u>Jan 1 - 60</u> and last saw him alive on <u>Jan 1 - 1960</u> Death occurred at <u>5 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>George A. O'Sullivan, M.D.</u>				22b. ADDRESS <u>7629 Ivory Ave.</u>			22c. DATE SIGNED <u>1-4-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-7-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Mo.,</u> (State)		
24. FUNERAL DIRECTOR <u>G. Wade Granberry</u>		ADDRESS <u>4202 Finney Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 4 1960</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>	

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edward G Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave

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.