RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-047821-

STATE FILE NUMBER

FILED VS JAN 9 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12353

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: INCARNATE WORD HOSPITAL
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 6247 ODELL AVE
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CARL Middle L. Last PARROTT
4. DATE OF DEATH: Month DEC Day 21 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: JUNE 15 1903
9. AGE (last birthday): 57
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): STEAMFITTER MIDWEST
10b. KIND OF BUSINESS OR INDUSTRY: PIPE CO.
11. BIRTHPLACE (City and state or country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY: U-S-A
13a. FATHER'S NAME: WILLIAM C PARROTT
13b. MOTHER'S MAIDEN NAME: WILHELMINA HOTH
14. NAME OF HUSBAND OR WIFE: MARIE PARROTT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 493-10-5247
17. INFORMANT: MARIE PARROTT Address: 6247 ODELL AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Esophageal hemorrhage	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Esophageal varices	indeterminat
DUE TO (c)	Portal cirrhosis of liver	"

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 581.0

PART III. If deceased was female, was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Nov. 19, 1957, to Dec 21, 1960 and last saw her/him alive on Dec 20, 1960
Death occurred at 10 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title) M.D.
22b. ADDRESS: 2730 Watson Rd.
22c. DATE SIGNED: 12-23-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: DEC 24 1960
23c. NAME OF CEMETERY OR CREMATORY: NEW PICKERS CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS MO.
24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: DEC 24 1960
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

DOCUMENT

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 b

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 434

P. O. Address 2906 x

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.