

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012068

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 655

AMENDED, ✓

FILED VS MAR 17 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jennings Mo.</u>	Length of stay in 1b <u>3 Months</u>	c. CITY OR TOWN <u>Jennings</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>6512 Lillian Ave.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6512 Lillian Ave.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Ann</u> Last <u>Parker</u>			4. DATE OF DEATH Month <u>March</u> Day <u>7th</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-72</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Mississippi</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Thomas Payne</u>		13b. MOTHER'S MAIDEN NAME <u>Louise Dyer</u>		14. NAME OF HUSBAND OR WIFE <u>Late O.M. Parker</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. <u>none</u>		17. INFORMANT Address <u>Mrs. Welton Mooring 6512 Lillian 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>CORONARY THROMBOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>5 YEARS</u> <u>10 YEARS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>MYOCARDIAL INSUFFICIENCY.</u>	
	DUE TO (c) <u>CARDIO-VASCULAR DISEASE</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 checked="" 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.)	
20c. TIME OF INJURY Hour <u>2:55 P.M.</u> Month, Day, Year <u>Sept 3 1961</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Sept 3 1961</u> to <u>3-7-61</u> and last saw her <u>alive</u> on <u>3-7-61</u> Death occurred at <u>2:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>J. E. Farley MD</u> (Degree or title)		22b. ADDRESS <u>6623 LILLIAN ST. LOUIS MO</u>		22c. DATE SIGNED <u>3-7-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Rail)</u>	23b. DATE <u>3-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Belzone Mississippi</u>	23d. LOCATION (City, town, or county) (State) <u>Belzone Miss.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 SoKingshighway</u>		25. DATE RECD. BY LOCAL REG. <u>3-8-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

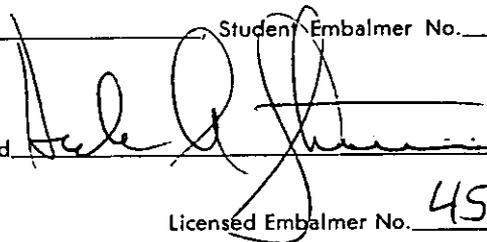
BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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  _____
Licensed Embalmer No. 4533

P. O. Address _____

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.