

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

15113

1. PLACE OF DEATH

County Stoddard Registration District No. 627
 Township Union Primary Registration District No. ~~427~~
 City Rolling (No. 5879) St. _____ Ward _____

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lillian Parker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 21 - 1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 2 18

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Farmer 1
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

10. NAME OF FATHER Joshua Parker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Barah Taylor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT (Address) Mrs Hazel Dembelle Pickering

15. FILED 4/30 1931 Mrs. W. B. Smith REGISTRAR
May 7 - 31 C. P. Weyer

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 18 1931

17. I HEREBY CERTIFY, That I attended deceased from Apr 30th 1920, to Apr 18th 1931 that I last saw him alive on Apr 18th 1931 and that death occurred, on the date stated above, at 7-40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
valvular disease of heart
chronic
99A
99A (duration) 12 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) mesenteric Peritonitis
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH. 920

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) L. D. Dean M. D.
 , 19 _____ (Address) Maryville Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maryville DATE OF BURIAL Apr 20 1931

20. UNDERTAKER Price Fun Co Maryville Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 27 1931

M.E.C.

