

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

Do not use this space.

Parley

1. PLACE OF DEATH

County..... Registration District No. *223*
 Township..... Primary Registration District No. *22301P*
 City..... (No. *Memorial Home*) St. *2609 S. Grand* Ward.....

File No. **21312**

Registered No. **5095**

2. FULL NAME

Mrs Mary L Parley
 (a) Residence. No. *2609 S Grand* St. *16* Ward.....
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*
 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 *Harrison L. Parley*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jun 30 18 50*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
85 1

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

9. BIRTHPLACE (CITY OR TOWN) *Mechanicsville*
 (STATE OR COUNTRY) *Ill*

10. NAME OF FATHER *Mr Joel Churchill*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Bone Co*
 (STATE OR COUNTRY) *Ill*

12. MAIDEN NAME OF MOTHER *Lucretia J. Vandurant*

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

14. INFORMANT *Mrs S Shaw*
 (Address) *2609 S Grand Blvd*

15. FILED *111*, 19*33*
J F Bredeck
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 9 19 33*
 17. I HEREBY CERTIFY That I attended deceased from *December 19 28* to *June 9 19 33* that I last saw her *alive* on *June 9 19 33*, 19*33*, and that death occurred, on the date stated above, at *7 30 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mammary Carcinoma
Right Breast
 (duration) *2* yrs. mos. ds.
 CONTRIBUTORY *Secondary Malaria*
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
 WAS THERE AN AUTOPSY? *No*
 WHAT TEST CONFIRMED DIAGNOSIS? *Every*
 (Signed) *W. D. Superkula*
 (Address) *3103 Arsenal St*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St Matthews Cem.* DATE OF BURIAL *June 19 33*

20. UNDERTAKER *Craig Constable Co Washington*
 ADDRESS *1416*

R. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

