

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.

REC'D MAR 8 1939

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

6918
Do not use this space.

1. PLACE OF DEATH

(a) County JEFFERSON Registration District No. 47/5
 (b) Township MERAMEC Primary Registration District No. 5580
 (c) City..... (d) Street No. ST. JOSEPH'S HILL INFIRMARY, EUREKA, MO. Registered No. 11-100
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred - yrs. 4 mos. 7 ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Edward Parker

(a) Residence, No. Eureka, Mo. = formerly of Webster Groves, Mo
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 KATHERINE DOBBINS
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/3/1873
 7. AGE YEARS 66 MONTHS — DAYS 1 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RIVERBOAT PILOT, RETIRED
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 1920 11. Total time (years) spent in this occupation 25

12. BIRTHPLACE (CITY OR TOWN) ST. LOUIS, MO. (STATE OR COUNTRY)

FATHER 13. NAME THOMAS PARKER

14. BIRTHPLACE (CITY OR TOWN) OHIO (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME SARA H MORSE

16. BIRTHPLACE (CITY OR TOWN) VIRGINIA (STATE OR COUNTRY)

17. INFORMANT ST. JOSEPH'S HILL INFIRMARY (ADDRESS) By Brother Brouventur, O.S.F.

18. BURIAL, CREMATION, OR REMOVAL PLACE ST. LOUIS, MO. DATE FEB. 4 1939

19. FUNERAL DIRECTOR (NAME) CHAS. J. KRON UND. Co., INC. (ADDRESS) ST. LOUIS, MO.

20. FILED 2/4 39 JAMES A. TORRENT Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1939, to Feb 3, 1939
 I last saw him alive on Feb. 3, 1939. Death is said to have occurred on the date stated above, at 7:25 a.m.
 The principal cause of death and related causes of importance were as follows:

Date of onset
Broncho-pneumonia
 Other contributory causes of importance: IPW

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) Jesse B. Sargent, M. D.
 (Address) Eureka, Mo.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.