

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.

Registration District No. 250

Primary Registration District No. 5348

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town "Rural" Union Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ---  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Yrs.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Thomas Parker

3. (b) If veteran, name war --- 3. (c) Social Security No. ---

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nancy Margaret Parker 6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased December 3 1860  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>1</u>	<u>13</u>	hr. min.

9. Birthplace Manchester Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Edward Parker

13. Birthplace Clay Co. Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Strong

15. Birthplace Nellie Parker Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]  
(b) Address Gallatin, Missouri

17. (a) Burial (b) Date thereof 1 18 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brown Cemetery

18. (a) Signature of funeral director [Signature]  
(b) Address Gallatin, Missouri

19. (a) Jan. 17-1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess  
(c) City or town "Rural" Union Township  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16  
year 1940 hour 11 minute 40 A. M.

21. I hereby certify that I attended the deceased from 1/2/40 19\_\_\_\_ to 1/12/40 19\_\_\_\_;  
that I last saw him alive on 1/12/40 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory Failure  
Heart Block - Hypertension  
Senility

Due to	<u>Heart Block - Hypertension</u>	Duration	<u>3 yrs</u>
Due to	<u>Senility</u>		<u>3 yrs</u>

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy Not done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (Means of injury)  
23. Signature [Signature] (Date or other) \_\_\_\_\_  
Address Gallatin Mo Date signed 1/17/40

PHYSICIAN  
Underline the cause to which death should be charged statistically

RECEIVED

District Health Officer No. 91.

District File Number 240-126

FEB 13 1940

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

*L. O. Richerson*

Licensed Embalmer No.

*3302*

P. O. Address

*Gallatin, Mo*

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

2209

Do not use this space.

1. PLACE OF DEATH  
(a) County Barren Registration District No. 250  
(b) Township Union Primary Registration District No. 3348 Registered No. 3  
(c) City..... (d) Street No..... St.  
(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. mos. ds. 0 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Thomas Parker  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-16 1940

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

19..... to ....., 19.....

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
79 1 13

I last saw h..... alive on ....., 19..... Death is said

to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
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).....  
11. Total time (years) spent in this occupation.....

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

13. NAME

Name of operation..... Date of.....

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

What test confirmed diagnosis?..... Was there an autopsy?.....

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

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

Accident, suicide, or homicide?..... Date of injury..... 19.....

17. INFORMANT (ADDRESS)

Where did injury occur?..... (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE..... DATE..... 19.....

Manner of injury.....

Nature of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify

20. FILED Jan. 17 1940 H. G. Hope Local Registrar.

(Signed) Edward C. Nixons

(Address) Regulation

