

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 561

Primary Registration District No. 5753

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Miller
(b) City or town Rural Saline
(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 2
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Katherine Parker
3. (b) If veteran, name war _____ 3. (c) Social Security No. no

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Thomas Parker, Jr. 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 20, 1861
(Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Saint Louis - Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Gottschammer
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Showls
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Della Schroeder
(b) Address Eldon, Missouri

17. (a) removal (b) Date thereof 3-23-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis, Missouri
Phillips Funeral Home

18. (a) Signature of funeral director _____
(b) Address Eldon, Missouri

19. (a) 3-23-1940 (b) Belle Hairier
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miller
(c) City or town Eldon, "Rural"
(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 March day 23rd
year 1940 hour 2 minute 50 P. M.

21. I hereby certify that I attended the deceased from Jan 20, 1940, to 3/23, 1940
that I last saw her alive on 3/16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Coronary Thrombosis 3/23/40

Due to Myocarditis ?

Other conditions (Include pregnancy within 3 months of death) jaundice

Major findings: Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (e) Means of injury _____

28. Signature H. D. Walker (M. D. or other) !
Address Eldon Mo Date signed 4/16/40

RECEIVED

Miller County Health Dept.

County File Number 40-43

Date Filed 4-11-40

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.....

Louis D. Phelan Registered Apprentice No.....
working under my personal supervision.

Signed Louis D. Phelan

Licensed Embalmer No. 2663

P. O. Address Eldon

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11728 7
Registrar's No. 21

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 361

Primary Registration District No. 3753

R

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH?
 (a) County Saline
 (b) City or town Saline
 (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 _____
 In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Katherine Parker

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased Nov 20 1861
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>4</u>	<u>3</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Mch 30 1940 (b) Belle Hayes
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (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 Feb day 23 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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) _____ (e) Means of injury _____

23. Signature G. D. Walker (M. D. or other) _____
 Address Eldon Mo Date signed _____

SUPPLEMENTAL

11728 (1940)