

REG. DIST. 13 1940
Registration District No. 19

Primary Registration District No. 4013

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Hickson
(b) City or town Rock Port
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 100 yrs years, months or days _____ (Specify whether)

3. (a) PRINT FULL NAME Joseph Richard 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
(b) Name of husband or wife Melona Jane Talley 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased 3 (Month) 5 (Day) 1853 (Year)

8. AGE: Years 87 Months 5 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Moving Contractor

11. Industry or business _____

MOTHER FATHER
12. Name Michael Parker
13. Birthplace Unknown (City, town, or county) N.C. (State or foreign country)
14. Maiden name Hannah Knight
15. Birthplace Unknown (City, town, or county) Leva (State or foreign country)

16. (a) Informant's own signature Mrs Jessie Waits
(b) Address Turkey Mo

17. (a) Burial (b) Date thereof 8-27-1940
(Special, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation High Creek Cem

18. (a) Signature of funeral director Rock Port Mo
(b) Address _____

19. (a) Aug 25 1940 (b) Mary H. Chamberlain
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickson
(c) City or town Rock Port (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 Aug day 22nd
year 1940 hour 8 minute 22 AM.
21. I hereby certify that I attended the deceased from Aug 21
1940, to Aug 22 1940;
that I last saw him alive on Aug 22 1940
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Pulmonary edema</u>	<u>2 da.</u>
Due to <u>Chronic myocarditis</u>	<u>years</u>
<u>hypertensive heart disease</u>	<u>years</u>
Due to _____	_____

Other conditions (include pregnancy within 3 months of death) 42C

Major findings:
Of operations _____
Of autopsy _____
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? 16
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature F. H. Fields (M. D. or other) MD
Address Rock Port, Mo. Date signed 8-27-40

WHITE PAPER—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.

1 X1951

RECEIVED
District Health Officer No. 11,
District File Number 940-1409
City of St. Louis
SEP 20 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 W. B. Bartholomew
Licensed Embalmer No. 3173
P. O. Address Rock Port, 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.