

No. 2  
1-12-40  
-17-39

JAN 10 1941

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **1366**

1. PLACE OF DEATH:

(a) County **BUCHANAN**

(b) City or town **ST. JOSEPH** **3**

(c) Name of hospital or institution: **STATE HOSPITAL No. 2**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 mos 27 days**  
(Specify whether)

In this community **4 Months - 27 days**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **St. Louis Mo**  
(If outside city or town limits, write "RURAL")

(d) Street No. **3235 Lawton Ave**  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME: **Eugene Parker**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **27**  
year **1940** hour **840** minute **P.** M.

4. Sex **male** 5. Color or race **col** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife **none** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Feb 27 1891**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug 1**, 19**40** to **Dec 27**, 19**40**  
that I last saw him alive on **Dec 27**, 19**40**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

**49** **10** **0** \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **General Paralysis of Insane Syphilis**

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation **Cook** **9**

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name **Unknown** **9**

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

14. Maiden name **Unknown**

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant **State Hospital records**

(b) Address **St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **12-31-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **State Hospital Grounds**

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? **Home 85**  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director **Tracy Barry Funeral**  
**218 South 10th St**

(b) Address \_\_\_\_\_

19. (a) **Dec 31 1940** (b) **J. C. Burch**  
(Date received local registrar) (Registrar's signature)

23. Signature **J. C. Burch** (M. D. or other) \_\_\_\_\_  
Address **State Hosp # 2** Date signed **12-31-40**

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

1  
5  
7

*Body was not embalmed*

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. *0270*

P. O. Address *St Joseph, 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, fact should be so stated above.