

Registration District No. 954

Primary Registration District No. 5979^a

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Rural Carroll Twp
(c) Name of hospital or institution: XXX
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XX
In this community all his life
years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

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

8. (a) PRINT FULL NAME Ray Gene Parker

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

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

6. (b) Name of husband or wife XX 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased April 11 1933
(Month) (Day) (Year)

8. AGE: Years 7 Months 2 Days 24 If less than one day hr. min.

9. Birthplace Reynolds Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business XX

12. Name Robert Parker

13. Birthplace Reynolds Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Lola Martin

15. Birthplace Reynolds Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Lola Parker

(b) Address Bunker Mo

17. (a) burial (b) Date thereof 7/6/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Mo

18. (a) Signature of funeral director Charles J. ...

(b) Address Salem Mo

19. (a) July 5 40 (b) Wendell ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 5
year 40 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from 6/20-40
1940 to 6/5/40 1940
that I last saw him alive on 6/4/40 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia
Due to Whooping Cough
Due to Infant's death

Other conditions (Includes pregnancy within 3 months of death) 9

Major findings: Of operations 9
Of autopsy

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? 740 (Specify type of place)
(e) Means of injury

23. Signature W. H. ... (M. D. or other)
Address Chicago Date signed 7/8/40

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

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

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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. *X 21*

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.