DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1941

X26390

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

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32635

Registration District No. 7195 Primary Registration District No. 220 Registrar's No. 1873

1. PLACE OF DEATH:
(a) County: St Louis
(b) City or town: Koch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 48 days (Specify whether years, months or days)
In this community 36 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: ~~St Louis~~ 00
(c) City or town: St Louis 17 (If outside city or town limits, write "RURAL")
(d) Street No. 4061 Hartford 9 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: EVERETT L. PARKER
3. (b) If veteran, name war:
3. (c) Social Security No. 488-02-3161
4. Sex: Male
5. Color or race: white
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mamie Parker nee Pidgeon
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Feb (Month) 24 (Day) 1888 (Year)

8. AGE: Years 53 Months 6 Days 15 If less than one day hr. min.

9. Birthplace: Blackrock (City, town, or county) / Ark (State or foreign country)
10. Usual occupation: Candy maker
11. Industry or business:
FATHER 12. Name: William Henry Parker
FATHER 13. Birthplace: Pittsfield (City, town, or county) / Mass (State or foreign country)
MOTHER 14. Maiden name: Emma Grable
MOTHER 15. Birthplace: / Wisconsin (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Record
(b) Address: Robert Koch Hospital
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: Sept. 11-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Sunset PARK
18. (a) Signature of funeral director: Thorbitts & Son
(b) Address: 2916 Bayard St
19. (a) SEP 10 1941 (Date received local registrar) (b) C. J. McGarron (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8 year 1941 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 22 1941, to Sept 8 1941; that I last saw h. alive on Sept 8 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	10 mo +
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 hr

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Frank Cohen (M. D. or other) M.D.
Address: Robert Koch Hospital Date signed Sept 9/41

(Licensed Embalmer's Statement on Reverse Side)

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 Leo Budde, Registered Apprentice No. ..... working under my personal supervision.

Signed Leo Budde

Licensed Embalmer No. 3989

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-8-21-41
I X29288

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32635

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1873

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Koch
(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 (Specify whether years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Everett L. Parker
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Feb. 24 1888 (Month) (Day) (Year)

8. AGE: Years 53 Months 6 Days If less than one day 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 9-10-41 (Date received local registrar) (b) R. J. McGarrahan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day
year 1941 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.

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

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY