

U.S. No. 2
FORM 5-42
Rev. 5-17-39

15087

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

MAY 10 1943
Registration District No. 273

Primary Registration District No. 5914

Registrar's No. 46

1. PLACE OF DEATH: Perry

(a) County Perry

(b) City or town Seventy Six Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Prayer's Hill
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 63-0-14 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Perry

(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 Arthur Parker

3. (b) If veteran, name war _____

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
year 1943 hour 2 minute _____ P. M.

4. Sex Male 5. Color or Race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Birdie Parker

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased April 10 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 5th 1942 to April 24th 1943
that I last saw him alive on April 22nd 1943
and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 0 Days 14 If less than one day _____ hr. _____ min.

Immediate cause of death: Carcinoma of Rectum Duration 1 year

9. Birthplace Perry Co Missouri
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation Farmer

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

11. Industry or business _____

Major findings: Of operations Rectal Carcinoma

12. Name John Parker

Of autopsy _____

13. Birthplace Perry Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Rhyn

15. Birthplace Perry Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Birdie Parker

(b) Address Seventy Six Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-1943
(Month) (Day) (Year)

(c) Place: burial or cremation Shiloh Mo.

18. (a) Signature of funeral director Volunteer Sons

(b) Address Perryville Mo.

19. (a) 4-26-43 (b) Thos G Elder
(Date received local registrar) (Registrar's signature)

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 Theodore Fischer (M. D. or other) M.D.

Address Altensburg, Mo Date signed 4/26/43

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

100-111

1326

RECEIVED

District Health Officer No. 4
District File Number 543-2220
Date Filed 5-8-43

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 Wallace Young
Licensed Embalmer No. 4027
P. O. Address Perryville 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15087

Registration District No. 273

Primary Registration District No. 5-914

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Perry

(b) City or town Serinity Mo
(If outside city or town limits, give "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

In this community _____ life years, months or days) (Specify whether

3. (a) PRINT FULL NAME Arthur Parker

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

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

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (if less than one day) min. _____

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Perry

(c) City or town Serinity Mo
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her 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 _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

S-15087