V. S. No. 2
100M—2-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30268

FILED SEP 17 1943 318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 8037

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mississippi (b) County Humphrey

(c) City or town Belzoni
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Route #1
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Octavius Parker

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased April (Month) 8 (Day) 1870 (Year)

8. AGE: Years 73 | Months 5 | Days 0 | If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business Agricultural

FATHER
12. Name Thomas Parker
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Lucinda Keene
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Alonzo Parker
(b) Address 119 Naylor Ave, Pine Lawn, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Leland Mississippi

18. (a) Signature of funeral director Albert H. Hoppe, Inc
(b) Address 4700 Washington Blvd,

19. (a) SEP 9 1943 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8
year 1943 hour 5:15 minute P. M.

21. I hereby certify that I attended the deceased from 9-4-43, 1945, to 9-8-, 1943
that I last saw him alive on 9-8-, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Due to Pyelonephritis, bilateral Calculous	
Due to 134	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Chronic & acute pyelonephritis, bilateral c̄ hydroureters	

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 A. T. Eschinger (M. D. or other)

Address BARNES HOSPITAL Date signed

(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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Albert E. Kaffe

Licensed Embalmer No. 2971

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, fact should be so stated above.