

Registration District No. ....

Primary Registration District No. ....

**1. PLACE OF DEATH:**

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis Children's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Madison  
(c) City or town Marquand  
(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 PARKER, JUDITH MARLENE

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

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

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

7. Birth date of deceased September 11 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 27 hr. \_\_\_\_\_ min.

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

10. Usual occupation Infant

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

12. Name Francis G. Parker

13. Birthplace Winnepeg Canada  
(City, town, or county) (State or foreign country)

14. Maiden name Mable Ellen Bone

15. Birthplace Waterman Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Otha B. Bone  
(b) Address Marquand, Mo.

17. (a) Burial (b) Date thereof 1-10-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marquand, Missouri

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

19. (a) JAN 9 1945 J. F. Bredick  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 1 day 8  
year 45 hour 3 minute 10 P.M.

21. I hereby certify that I attended the deceased from 1-4-45 to 1-8-45, 1945.

that I last saw her alive on 1-8-45, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death:  
Sepsisemia?  
Prolapse of Rectum

Due to \_\_\_\_\_  
Due to 123:4

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

Major findings: Of operations \_\_\_\_\_

Of autopsy no significant findings

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 R. V. Blottner (M. D. or other) \_\_\_\_\_  
Address 177 Dr. Kuyper Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

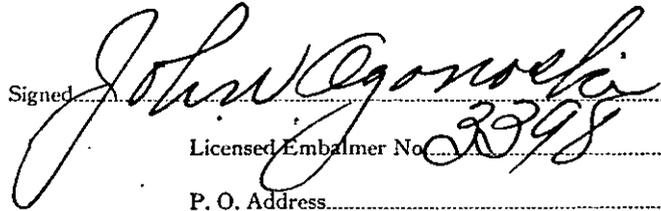
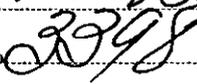
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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. .....  
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.**