

FILED MAR 28 1945
818

Primary Registration District No. **1003**

Registrar's No. **2519**

1. PLACE OF DEATH:

(a) County.....
(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)

3. (a) PRINT FULL NAME **Charles Raymond Parker.**

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

4. Sex **Male** 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: **November 30 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 16 hr. min.

9. Birthplace: **Shreveport Louisiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business.....

MOTHER FATHER {
12. Name **Cecil Parker**
13. Birthplace **Shreveport Louisiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Virginia Baldwin**
15. Birthplace **Shreveport Louisiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Cecil Parker**
(b) Address **Shreveport, La.**

17. (a) **Removal** (b) Date thereof **3-16-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Shreveport, La.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **MAR 19 1945** **J. F. Brudek**
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Louisiana** (b) County..... **Caddo**
(c) City or town..... **Shreveport**
(If outside city or town limits, write "RURAL")
(d) Street No. **2729 W. College Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **16**
year **1945** hour **10** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **2-15-45** to **3-16-45**
that I last saw him alive on **3-16-45**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Meningococcus Meningitis

Due to.....
6

Due to.....

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

Major findings:
Of operations.....

Of autopsy **Chronic Basilar Meningitis**

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?

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

23. Signature **Gilbert B. Foster** (M. D. or other)
Address **500 S. Kingshighway** Date signed.....

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

2519

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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 *John Ogonoske*
Licensed Embalmer No. *338*
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.