

FILED JUN 9 1945

State File No. \_\_\_\_\_

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 177

1. PLACE OF DEATH:

(a) County Calloway

(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hospital no. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Calloway

(c) City or town Fulton 19  
(If outside city or town limits, write "RURAL")

(d) Street No. 1  
(If rural, give location) 2

(e) Citizen of foreign country? no (Yes or No) 2  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LOU PARKER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25  
year 1945 hour 2 minute 25 A.M.

21. I hereby certify that I attended the deceased from May 18 1945  
to May 25 1945  
that I last saw her alive on May 24 1945  
and that death occurred on the date and hour stated above.

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

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

7. Birth date of deceased: DK  
(Month) (Day) (Year)

Immediate cause of death: Chronic myo carditis

Duration \_\_\_\_\_

8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Generalized arterio sclerosis  
(Include pregnancy within 3 months of death)

9. Birthplace Calloway Co. MO  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

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

Of autopsy 93d

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

12. Name Sam Shaw

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

14. Maiden name DK 9

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

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? \_\_\_\_\_

16. (a) Informant Records State Hosp no 1

(b) Address Hilton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26, 45  
(Month) (Day) (Year)

(c) Place: burial or cremation White Cloud

18. (a) Signature of funeral director Wm. H. Morgan

(b) Address 412 Cant St. Fulton, Mo

19. May 26, 1945 (Date of local registrar) (b) Jesse Mousaichoff (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature R. P. Price (M. D. or other) MA

Address Fulton MO Date signed 5/25/45

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

14  
1  
2

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 6-7-45

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 Glen Y. Marpin

Licensed Embalmer No. 2725

P. O. Address Fulton, 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.