

No. 2
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-17-39
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32080

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 31 1946

8397

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 days
(Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4537 St. Ferdinand
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas Parrish

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 2

5. Color or race Negro

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

6. (b) Name of husband or wife Dulcinea Parrish

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased: Feb. 8, 1874
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>7</u>	<u>19</u>	hr. _____ min. _____

9. Birthplace: ? Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Minister

11. Industry or business _____

12. Name Charles Parrish

13. Birthplace ? Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Clara Jones

15. Birthplace ? Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant Dulcinea Parrish

(b) Address 4537 St. Ferdinand

17. (a) Burial (b) Date thereof 10/1/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cem.

18. (a) Signature of funeral director Russell Undt. Co.

(b) Address 2832 St. J. F. Brede

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1946 hour 5 minute 15 A. M.

21. I hereby certify that I attended the deceased from Aug. 8, 1946 to Sept. 27, 1946
that I last saw him alive on Sept. 27, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Transverse Colon

Duration: Undet.

Due to _____

Due to _____

Other conditions: None
(Include pregnancy within 5 months of death)

Major findings: _____
Of operations _____

Of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 _____

Signature E. B. Williams (M. D. or other) _____

Address 2601 N. White Date signed _____

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

MOTHER FATHER

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..... 3371

P. O. Address..... 477 Lane

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.