

S. No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44241

FILED DEC 23 1946

Primary Registration District No. 3039

Registrar's No. 100

1. PLACE OF DEATH:

(a) County Lincoln

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

(c) Name of hospital or institution: /

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 25 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln

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

(d) Street No. 119 E. Gracia
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Sam J Parker

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2
year 1946 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Janie Murray Parker 6. (c) Age of husband or wife if alive 68 years

Birth date of deceased December 25 1857
(Month) (Day) (Year)

Immediate cause of death coronary occlusion

Due to arteriosclerosis

Due to _____

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

88 11 7 hr. _____ min.

9. Birthplace Bloomington Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Police man

11. Industry or business _____

12. Name George S Parker

13. Birthplace Parkersburg W. Va
(City, town, or county) (State or foreign country)

14. Maiden name Jennie Hobin

15. Birthplace W. Va
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sam Parker

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Dec 3 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet

18. (a) Signature of funeral director James McLaughlin

(b) Address Marceline Mo

19. (a) 12-8-46 (b) J. E. Shelton
(Date received local registrar) (Registrar's signature)

Major findings: Of operations gtd

Of autopsy _____

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 Philip A. Ottman (M. D. or other) M.D.
Address Marceline Mo Date signed Dec 2 46

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

MOTHER FATHER

168

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Dale Bunch*

Licensed Embalmer No..... *4088*

P. O. Address..... *Marceline 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.

Registration District No. *385*

Primary Registration District No. *3089*

Registrar's No. *100*

1. PLACE OF DEATH:

(a) County *Lincoln*
(b) City or town *Marceline*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 *Sam J. Parker*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *m*

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

7. Birth date of deceased *Dec 25 1951*
(Month) (Day) (Year)

8. AGE: Years *88* Months *11* Days _____ If less than one day, hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) *mo*

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) *12-4-76* (b) *L. E. Shelton*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year *1976* Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

41294