

FILED JAN 19 1948

Registration District No. 185

Primary Registration District No. 4300

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Laclede
(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 all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58
(c) City or town Laclede 5
(If outside city or town limits, write "RURAL") 7
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES ROY PARKER

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

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

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

7. Birth date of deceased July 8 1882
(Monthly) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 5 23 hr. min.

9. Birthplace Laclede, Linn Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Feed mixer

11. Industry or business Henderson Produce Co.

12. Name Charles Henry Parker

13. Birthplace Mount Sterling, Brown Co. Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Jane Hill

15. Birthplace Scott Co. Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Adia Anderson
(b) Address Laclede, Mo., R.R.

17. (a) Burial (b) Date thereof Jan. 4, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laclede, Mo.

18. (a) Signature of funeral director McPherson
(b) Address Laclede, Mo.

19. (a) 1-3-48 (b) Chris. Montano
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
year 1947 hour 6 minute _____ P. M.

21. I hereby certify that I attended the deceased from 2 P.M.
Dec. 31 1947 to 6 P.M. Dec 31 1947

that I last saw him alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Duration 4 hrs.

Due to Cause unknown

Due to _____

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

Major findings: Of operations 737

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) (c) Means of injury 2

23. Signature W. J. Lohman (M. D. or other) Dr.

Address Brookfield, Mo. Date signed 1-3-48

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

MOTHER FATHER

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... W. J. Thorne

Licensed Embalmer No. 2876

P. O. Address Laluda, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 195

Primary Registration District No. 4300

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lin
(b) City or town Lacked
(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 Charles R. 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 Div

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 5 (If less than one day, hr. _____ min. _____)

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Jan 30 1948 (b) Chris A. Martens
(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 Feb Day 14 Year 1948 Hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

Due to _____

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

Major findings: Of operations _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-4445a