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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29496**

FILED SEP 27 1948

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **793**

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

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: O'Reilly VA Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Month 20 Days  
(Specify whether In this community 1 Month 20 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County W

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

(d) Street No. 4605 Cleveland St.  
(If rural, give location)

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

3: (a) PRINT FULL NAME FRANK C. PARKER

3. (b) If veteran, name war WW I

3. (c) Social Security No. Unk.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 20  
year 1948 hour 4 minute 55 PM

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased February 9, 1892  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from August 1, 1948 to September 20, 1948, that I last saw him alive on September 20, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic, far advanced, active Duration \_\_\_\_\_

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

56 9 20 4 hr. 55 min.

9. Birthplace Hot Springs, Arkansas /  
(City, town, or county) (State or foreign country)

10. Usual occupation Order Clerk

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

12. Name Frank Parker

13. Birthplace Tenn. /  
(City, town, or county) (State or foreign country)

14. Maiden name Ophelia Culbreth

15. Birthplace Georgia /  
(City, town, or county) (State or foreign country)

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant VA Records

(b) Address O'Reilly VAH, Springfield, Mo.

17. (a) Reinterred (b) Date thereof 9-21-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director Norman Schaff While at work? \_\_\_\_\_  
(b) Address Springfield Mo (c) Means of injury \_\_\_\_\_

19. (a) 9-22-48 (b) W. E. Haulley MD  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

23. Signature Paul L. Eisele (M. D. or other) \_\_\_\_\_  
Address O'Reilly VAH, Springfield, Mo. Date signed 9-21-48

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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 *L. A. Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Farmfield 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.**