

FILED OCT 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32093

State File No.

BIRTH NO. <u>0</u>		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3069</u>		Registrar's No. <u>2369</u>	
1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Keokuk Mo</u>		c. LENGTH OF STAY (In this place) <u>3 mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis Mo 4356</u>		d. STREET ADDRESS (If rural, give location) <u>7067 Arcadia Ave</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St Marys Hosp</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 1 1950</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>OLIVE</u>		b. (Middle) <u>FERN</u>		c. (Last) <u>PARRISH</u>		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>		8. DATE OF BIRTH <u>Feb 10-1886</u>	
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unkerson</u>			13b. MOTHER'S MAIDEN NAME <u>Unkerson</u>			14. NAME OF HUSBAND OR WIFE <u>Harvey Parrish</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HB Parrish 7067 Arcadia Ave</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomas</u>		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Cervix</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) <u></u>				DUE TO (c) <u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>171X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>171X</u>			
22. I hereby certify that I attended the deceased from <u>July 1, 1950</u> to <u>Oct 1, 1950</u> , that I last saw the deceased alive on <u>Oct 1, 1950</u> and that death occurred at <u>2:30 am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Theresaella M. D.</u>				23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>10/3/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 3-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Mother's Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>	
DATE REC'D BY LOCAL REG. <u>10-3-50</u>		REGISTRAR'S SIGNATURE <u>W. Donke</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Donke</u>		ADDRESS <u>1531 Dayton Rd</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Kusala

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.....

..... Student Embalmer No.

.....
working under my personal supervision.

Student
Student Embalmer

Signed.....

J. W. B. Embelby
Licensed Embalmer No. *3657*

P. O. Address.....

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.