

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24312

State File No. 6313

1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		2149	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4945 Devonshire Ave				1st STREET ADDRESS (If rural, give location) 4945 Devonshire Ave			
3. NAME OF DECEASED (Type or Print) Parent, C. Bledgett			4. DATE OF DEATH (Month) (Day) (Year) 7-14-1951				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-7-1893	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 YEAR Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent		10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue Dept		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Bledgett		13b. MOTHER'S MAIDEN NAME Nettie Bell		14. NAME OF HUSBAND OR WIFE Marcia Bledgett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War I None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marcia Bledgett 4945 Devonshire Ave			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY THROMBOSIS				INTERVAL BETWEEN ONSET AND DEATH ACUTE	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____			
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? 4201			
22. I hereby certify that I attended the deceased from 3/10 , 19 48 , to 7/14 , 19 51 , that I last saw the deceased alive on 7/14 , 19 51 , and that death occurred at 7:55 P.m. , from the causes and on the date stated above.							
23a. SIGNATURE Thomas W. Parker (Degree or title) M.D.				23b. ADDRESS 4660 Maryland		23c. DATE SIGNED 7/16/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE July 18, 1951	24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) 7600 St. Charles Rd. Mo.		
DATE REC'D BY LOCAL REG. JUL 16 1951		REGISTRAR'S SIGNATURE J. B. Parker		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 6409 Graves Ave			

Dr. Parker 4660 Maryland
RO 6074 10/20/51
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Yau M. Sizemore

Signed

Student Embalmer

Licensed Embalmer No. *04343*

P. O. Address *St Louis 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.