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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40977**  
Registrar's No. **10340**

FILED NOV 19 1953

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>life</b>		c. CITY OR TOWN <b>St. Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Anthony Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>17 3153 Longfellow Blvd.</b>			
3. NAME OF DECEASED (Type or Print) <b>MARY</b>		a. (First)	b. (Middle)	c. (Last) <b>PARKER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 30, 1953</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>		8. DATE OF BIRTH <b>Oct. 30, 1953</b>	9. AGE (In years last birthday) <b>5 min.</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>J. Finley Parker</b>		13b. MOTHER'S MAIDEN NAME <b>Delores J. Ruga</b>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>J. Finley Parker</b>		18. ADDRESS <b>3153 Longfellow Blvd.</b>		19. MEDICAL CERTIFICATION	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Premature Infant</b>  ANTECEDENT CAUSES <b>24 weeks gestation</b> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Twin</b>		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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>774X</b>		22. I hereby certify that I attended the deceased from <b>10/30, 1953</b> to <b>10/30, 1953</b> , that I last saw the deceased alive on <b>10/30, 1953</b> and that death occurred at <b>5:00 Pm.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Walter P. ...</b>		23b. ADDRESS <b>4617 W. ...</b>		23c. DATE SIGNED <b>10/31/53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>Oct. 31, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>		DATE REC'D BY LOCAL REG. <b>OCT 31 1953</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Beiderwieden F.H. Inc., 1936 St. Louis Av.</b>		(Licensed Embalmer's Statement on Reverse Side)			

DR. WALTER T. GUNN  
4617 Dahlia Av.,  
10-11 A.M. Saturday

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 .....  
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. ....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.