

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44419

FILED DEC 17 1953

State File No.

BIRTH NO. 85093 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11623

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 Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 3 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2069			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips				d. STREET ADDRESS (If rural, give location) 6 4742 Northland					
3. NAME OF DECEASED (Type or Print) a. (First) Catherine b. (Middle) Parker c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 11 8 53						
5. SEX Fem. 3		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 11-5-53			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME James Parker			13b. MOTHER'S MAIDEN NAME Gussie Ashford			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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Miss E. M. Sherard R.R. 2601 N. Whittier		ADDRESS			
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth ANTECEDENT CAUSES DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 776x					
22. I hereby certify that I attended the deceased from 11-5-1953 , to 11-8-1953 , that I last saw the deceased alive on 11-8-1953 , and that death occurred at 1:39a m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) William N. Sinkler, M.D.				23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 12-3-53			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-31-53		24c. NAME OF CEMETERY OR CREMATORY Anatomical House		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. DEC 9 1953		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE SERVICE ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, 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 _____

Student Embalmer No. _____

working under my personal supervision.

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