

FILED FEB 2 - 1955

## STANDARD CERTIFICATE OF DEATH

2513

State File No. \_\_\_\_\_

1003

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. \_\_\_\_\_

Registrar's No. 0197

|   |                           |   |  |   |   |   |   |
|---|---------------------------|---|--|---|---|---|---|
| BIRTH NO. _____   |                           | REG. DIST. NO. 318  |  | PRIMARY REG. DIST. NO. _____  |   | Registrar's No. 0197  |   |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |                           |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo.</u><br>b. COUNTY _____ |   |   |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>St. Louis</u>  |                           | c. LENGTH OF STAY (in this place) _____   |  | c. CITY OR TOWN <u>St. Louis</u>  |   | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>De Paul Hospital</u>   |                           |   |  | e. STREET ADDRESS (If rural, give location) <u>2209 2539 W. Sullivan Ave</u>  |   |   |   |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>Edward</u><br>b. (Middle) <u>P.</u><br>c. (Last) <u>Parley</u>  |                           |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>7 55</u> |   |   |   |   |
| 5. SEX <u>MO</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>  |  | 8. DATE OF BIRTH <u>July 21st. 1930</u>   | 9. AGE (In years last birthday) <u>24</u> | IF UNDER 1 YEAR Days _____  | IF UNDER 1 HR. Hours _____ Mins. _____                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>White-Rodgers</u>  |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis 0</u>   |   | 12. CITIZENRY OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13a. FATHER'S NAME <u>Pete Parley</u>   |                           | 13b. MOTHER'S MAIDEN NAME <u>Huma Roman</u>   |  | 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) <u>No</u>  |                           | 16. SOCIAL SECURITY NO. <u>494-26-8146</u>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Huma Parley-2539 W. Sullivan</u>  |   |   |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain Tumor</u><br><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>                        |
| 19a. DATE OF OPERATION <u>1/6/55</u>  |                           | 19b. MAJOR FINDINGS OF OPERATION <u>Brain Tumor</u>   |  |   |   |   | 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) _____   |   | 21f. HOW DID INJURY OCCUR? _____  |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   |                           | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |   |   |   |
| 22. I hereby certify that I attended the deceased from <u>1/3</u> , 19 <u>55</u> , to <u>1/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>55</u> and that death occurred at <u>4</u> <u>PM</u> , from the causes and on the date stated above. |                           |   |  |   |   |   |   |
| 23a. SIGNATURE (Degree or title) <u>Edmund A. Smith, M.D.</u>   |                           |   |  | 23b. ADDRESS <u>Government Mt. Bldg.</u>  |   | 23c. DATE SIGNED <u>1/7/55</u>  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 24b. DATE <u>1/10/55</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>  |   | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>  |   |
| DATE REC'D BY LOCAL REG. <u>JAN 8 1955</u>  |                           | REGISTRAR'S SIGNATURE <u>J. Earl Smith</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Lineally</u>  |   | ADDRESS <u>2228 St. Louis</u>   |   |

(Licensed Embalmer's Statement on Reverse Side)

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

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Bill C. [Signature]*.....

Licensed Embalmer No. *476*.....

P. O. Address *St. Louis*.....

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.