

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19837**

FILED JUL 2 1956

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **322**

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Cape Gir.	
b. CITY (If outside corporate limits, write RURAL and give township) Cape Girardeau		c. CITY (If outside corporate limits, write RURAL and give township) Cape Girardeau	
c. LENGTH OF STAY (in this place) 12 yrs.		d. STREET ADDRESS (If rural, give location) 317 S. Fountain	
d. FULL NAME OF HOSPITAL OR INSTITUTION 317 S. Fountain St.			

3. NAME OF DECEASED (Type or Print) Lonnie Parker		4. DATE OF DEATH (Month) (Day) (Year) June 20, 1956	
a. (First)		b. (Middle)	
c. (Last)			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 26, 1901
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (City and State or Foreign Country) Sanatobia, Miss.
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Geo. Parker	13b. MOTHER'S MAIDEN NAME Tena White	14. NAME OF HUSBAND OR WIFE Pearl Parker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. link	17. INFORMANT'S SIGNATURE OR NAME Mrs. Pearl Parker, 317 S. Fountain, Cape Gir., Mo.

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		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Hypertensive Myocarditis		
	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. Gastric Ulcer		1 yr.	

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) 443x
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?

22. I hereby certify that I attended the deceased from **6-5-1956**, to **6-20-1956**, that I last saw the deceased alive on **6-18-1956**, and that death occurred at **5:15 A** m., from the causes and on the date stated above.

23a. SIGNATURE William J. Oehler	(Degree or title)	23b. ADDRESS Cape Girardeau, Mo.	23c. DATE SIGNED 6-23-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 24, 1956	24c. NAME OF CEMETERY OR CREMATORY Fairmont Cemetery	24d. LOCATION (City, town, or county) (State) Cape Girardeau, Mo.
DATE REC'D BY LOCAL REG. 6-22-56	REGISTRAR'S SIGNATURE W. C. Summers	25. FUNERAL DIRECTOR'S SIGNATURE W. T. J. Sparks	ADDRESS Cape Girardeau, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 _____

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.