

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19700

STATE FILE NUMBER

FILED JUN 10 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1288

1. PLACE OF DEATH a. COUNTY St Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gardenville		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Gardenville		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7813 Delmont		Length of stay in lb 8 yrs	d. STREET ADDRESS 7813 Delmont (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles E Parker <i>First Middle Last</i>			4. DATE OF DEATH May 19 1957 <i>Month Day Year</i>		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 20 1893	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Medical Depot	11. BIRTHPLACE (City and state or country) Denver Colorado		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles L Parker			14. MOTHER'S MAIDEN NAME Sarah Cody		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes W W I		16. SOCIAL SECURITY NO. 498-03-7939	17. INFORMANT Address Winifred Parker 7813 Delmont		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) lung cancer Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Herbert R. Domke, M.D., Local Registrar			22b. ADDRESS 651 S. Brentwood Blvd.		22c. DATE SIGNED 5/24/57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/21/57	23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) St Louis County Mo
24. FUNERAL DIRECTOR ADDRESS J L Ziegenhein & Sons 7027 Gravois			25. DATE RECD. BY LOCAL REG. 5-20-57	26. REGISTRAR'S SIGNATURE Herbert R. Domke M.D.	

(Licensed Embalmer's Statement on Reverse Side)

300
-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

