

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042072

STATE FILE NUMBER

10547

FILED NOV 20 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300  
-57

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, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5811 Cabanne Avenue</b>		Length of stay in lb	d. STREET (If outside, give location) ADDRESS <b>5811 Cabanne Avenue</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>MAYBELLE ROSALIE PARKER</b>			4. DATE OF DEATH Month Day Year <b>November 2nd, 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4th, 1887</b>		9. AGE (In years) large (in day) Months Days Hours Min. <b>71 4 28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		11. BIRTHPLACE (City and state or country) <b>Vienna, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Robert L. Schenk</b>		13b. MOTHER'S MAIDEN NAME <b>UNK Dierker</b>		14. NAME OF HUSBAND OR WIFE <b>William R. Parker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war and date of service) <b>No None</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>James Parker</b> Address <b>5811 Cabanne Avenue</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis with myocardial infarct</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>4 years</b> <b>years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerotic heart disease</b>	
	DUE TO (c) <b>generalized arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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.) <b>4200</b>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 **Jan. 1955** to **Nov. 2, 1958** and last saw her alive on **Nov. 1, 1958**  
Death occurred at **5 P. M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Max A. Franklin</b> (Deceased's title)	22b. ADDRESS <b>M.D. Missouri Theater Building</b>	22c. DATE SIGNED <b>11/3/1958</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/5/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Vienna City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Vienna, Missouri</b>
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24. FUNERAL DIRECTOR <b>C. R. Lupton &amp; Sons</b> ADDRESS <b>7233 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 5 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Motor

MISSOURI THEATRE BUILDING  
2 to 5 PM  
Monday J.F. 14375

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*  
P. O. Address *St. Louis, Mo*

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.