Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000856
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY FRANKLIN	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN UNION 0561 0 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. FRANCIS — Length of stay in 1b —	d. STREET ADDRESS (If outside, give location) 28 SO. MCKINLEY — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First EDWARD	Middle A.	Last PARMENTIER	4. DATE OF DEATH	Month JAN. Day 13, Year 1959
5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH MAY 25, 1881	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 7 Days 18 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodian	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) PORT HUDSON, MO. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME MICHEL PARMENTIER	13b. MOTHER'S MAIDEN NAME MARY BEFFER	14. NAME OF HUSBAND OR WIFE AGNES PARMENTIER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 494-09-9097	17. INFORMANT AGNES PARMENTIER	Address UNION, MO.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 11 days

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) Gangrene of Left Foot 331X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1-2-59, to 1-13-59 and last saw ~~her~~ him alive on 1-12-59

Death occurred at 1:25 AM. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B G Stuhlmann M.D.	22b. ADDRESS Union, Mo	22c. DATE SIGNED 1-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-15-1959	23c. NAME OF CEMETERY OR CREMATORY IMMACULATE CONCEPTION	23d. LOCATION (City, town, or county) UNION, MO. (State)
24. FUNERAL DIRECTOR OLTMANN FUNERAL HOME	ADDRESS UNION, MO.	25. DATE RECD. BY LOCAL REG. 1/14/59	26. REGISTRAR'S SIGNATURE F.L. Heidmann G.L. Heidmann Dep

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... Signed Ralph Oltmann .....
Signature of Student Embalmer

Licensed Embalmer No. 4808 .....
P. O. Address Union, Ma .....

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.