

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023266

STATE FILE NUMBER

FILED JUL 7 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. 5981

300

1-57

0

793

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis - Little Rock Hospitals, Inc</b>		Length of stay in lb <b>3 days</b>	d. STREET ADDRESS (If outside, give location) <b>3240 Lafayette Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marie Schuh Parnell</b>			4. DATE OF DEATH Month Day Year <b>June 23, 1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1910</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lead Voucher Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	9. AGE (In years last birthday) <b>48</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11a. BIRTHPLACE (City and state or country) <b>Palestine, Tex.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>George Schuh, Sr.</b>		13b. MOTHER'S MAIDEN NAME <b>Elice (Unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Clyde Parnell</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>702-14-2721</b>	17. INFORMANT Address <b>Clyde Parnell 3240 Lafayette Ave.</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>Carcinoma of Cervix</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>171x</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"/>
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 Month, Day, Year 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 <b>June 20, 1959</b> to <b>June 23, 1959</b> and last saw her alive on <b>June 23, 1959</b> Death occurred at <b>9:15 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Rayall W. Clev. M.D.</b>		22b. ADDRESS <b>1755 So Grand St. Houston</b>	22c. DATE SIGNED <b>6-24-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6/25/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cem. (New Annex)</b>	23d. LOCATION (City, town, or county) (State) <b>Palestine, Texas</b>
24. FUNERAL DIRECTOR ADDRESS <b>Schnur Funeral Home - 3125 Lafayette Ave</b> <b>St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 24 59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <b>-md B.</b>

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 *Thomas R. Fenwick* .....

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

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.