

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS APR 22 1960

=60-017217

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 4026** STATE FILE NUMBER

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3243 Hawthorne | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3243 Hawthorne Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Herbert Lawrence Parker Jr. | | | 4. DATE OF DEATH Month Day Year April 10, 1960 | | | |
| 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 7-12-1894 | 9. AGE (last birthday) 65 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturers Rep. | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (City and state or country) St. Louis Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Herbert L. Parker | | 13b. MOTHER'S MAIDEN NAME EMILY KING | | 14. NAME OF HUSBAND OR WIFE Parker Fanita Griesedieck | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, or unknown) (If yes, give war or dates of service) Yes W.W. I | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Fanita G. Parker; 3243 Hawthorne | | |

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|---|-------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) 420.1 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

| | | | |
|---|---|--|-------|
| 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 a.m. p.m. Month, Day, Year | 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 **Feb 1960** to **4/10/60** and last saw him alive on **4/10/60**
 Death occurred at **8:30 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|-------------------------------|---|--|--|
| 22a. SIGNATURE (Degree or title) Jos. Grant M.D. | | 22b. ADDRESS 5521 S. Parkway | | 22c. DATE SIGNED 4/11/60 |
| 23a. BURIAL CREMATION REMOVAL (Specify) Burial | 23b. DATE 4-12-1960 | 23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery St. Louis Missouri. | | 23d. LOCATION (City, town, county) (State) |
| 24. FUNERAL DIRECTOR ADDRESS C.R. Lupton and Sons 7233 Delmar Blvd. | | 25. DATE RECD. BY LOCAL REG. APR 12 1960 | 26. REGISTRAR'S SIGNATURE Karl Smith, M.D. | |

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

0961

MAY 2 1961

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Clarence H. Muir

Licensed Embalmer No. 4011

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.