

FILED VS DEC 14 1960

=60-044045

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11643 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Length of stay in 1b <u>3 wks</u>	c. CITY OR TOWN <u>Thompsonville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>P.R.# 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>L.</u> Last <u>PARKER</u>			4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-1900</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	11. BIRTHPLACE (City and state or country) <u>FRANKLIN Co. ILL.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>William J. PARKER</u>		13b. MOTHER'S MAIDEN NAME <u>OLIVE PERRYMAN</u>		14. NAME OF HUSBAND OR WIFE <u>Sophie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Sophie Parker</u> Address <u>Thompsonville Ill</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
IMMEDIATE CAUSE (a) <u>Cerebral Edema</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Intercerebral hemorrhage</u> DUE TO (c) <u>Hypertension</u>			
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 checked="" type="checkbox"/> NO <input 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.) <u>3314</u>	
20c. TIME OF INJURY Hour <u>3:13</u> a.m. p.m. Month, Day, Year <u>Nov. 9, 1960</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>BARNES HOSPITAL</u>	20f. CITY, TOWN, OR LOCATION <u>FRANKLIN Co.</u> COUNTY STATE
21. I attended the deceased from <u>Nov. 9, 1960</u> to <u>Dec. 3, 1960</u> and last saw him alive on <u>Dec. 3, 1960</u> Death occurred at <u>3:13 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>H. Brudler, M.D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>12/14/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-5-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT HILL</u>	23d. LOCATION (City, town, or county) (State) <u>FRANKLIN Co. ILLINOIS</u>		
24. FUNERAL DIRECTOR <u>COURTNEY</u>		ADDRESS <u>GALATIA, ILL.</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 5 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

LATINOIS 2011

**STATEMENT BY LICENSED EMBALMER**

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 Karen Proloff

Licensed Embalmer No. 4356

P. O. Address St Louis Mo

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