

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037913

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9205**

FILED SEP 19 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY - - - | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY - - - | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b 5 weeks | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital | | d. STREET ADDRESS (If outside, give location) 5524 Murdock | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH |
| First Howard Middle Lester Last Parker | | | Month September Day 11 Year 1963 |
| 5. SEX M | 6. COLOR OR RACE W | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-12-02 |
| 9. AGE (last birthday) 61 | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) repairman | | 10b. KIND OF BUSINESS OR INDUSTRY SW. Bell Telephone | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME William Parker | |
| 13b. MOTHER'S MAIDEN NAME Emily (Unknown) | | 14. NAME OF HUSBAND OR WIFE Margaret A. Parker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. [REDACTED] | |
| 17. INFORMANT Mrs. Margaret Parker | | Address 5524 Murdock | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary failure Brain tumor (malignant) 1930 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 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 Sept 5 1963 to Sept 10 1963 and last saw her/him alive on Sept 10 1963 Death occurred at 5:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Francis S. Walker (Degree or title) | | 22b. ADDRESS 634 N. Grand | 22c. DATE SIGNED 9-13-63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 9-14-63 | 23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park | 23d. LOCATION (City, town, or county) (State) St. Louis, County, Mo. |
| 24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY ADDRESS 6464 Chippewa | | 25. DATE RECD. BY LOCAL REG. SEP 13 1963 | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. |

STATE-001

FORM

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Dr. Francis Walker
150 N. Keramee
PA-6-2802

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 Bill C. Dawson

Licensed Embalmer No. 4764

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.

634 N. Grand
JE 3-3430
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