

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Lafayette
Township _____
or
Village _____
or
City Adessa (NO. _____ St.: _____ Ward)

Registration District No. 464 File No. 18205
Primary Registration District No. 4277 Registered No. 11

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Thomas C. Parks

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED, WIDOWED OR DIVORCED <u>Married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>9</u> <u>October</u> <u>1911</u> (Month) (Day) (Year)		
AGE <u>31</u> yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-02</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Indiana</u>		
PARENTS	NAME OF FATHER <u>Kirk Parks</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>Heddrick</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kirk Parks
(ADDRESS) Adessa Mo
Filed May 9, 1911 H. Williams,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 April 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 20, 1911, to April 3, 1911, that I last saw him alive on April 2, 1911, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Psoriasis abscess
26 X 37
(Duration) 3 yrs. 2 mos. 1 ds.

Contributory _____
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. F. Mackey M. D.
April 9, 1911 (Address) Adessa, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted If not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL <u>Adessa Cem</u>	DATE OF BURIAL <u>4/4</u> , 1911
UNDERTAKER <u>L. C. Newman,</u>	ADDRESS <u>Adessa</u>

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*; *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis* of *lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CERTIFICATE OF DEATH

County Lafayette
Township _____
or _____
Village _____
or _____
City Odessa (NO. _____ St.: _____ Ward)Registration District No. 464File No. 18208Primary Registration District No. 4277Registered No. 11

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

Thomas E. Parks.

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>Apr 3rd Odessa Mo 1881</u> (Month) (Day) (Year)		
AGE <u>31</u> yrs. ____ mos. ____ ds.		If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) IndianaPARENTS
NAME OF FATHER Mark ParksBIRTHPLACE OF FATHER
(City or town, State or foreign country) KentuckyMAIDEN NAME OF MOTHER Susan NiddrethBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mark Parks(ADDRESS) Odessa Mo.Filed July 8 1911 H. Williams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 3, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from April 20, 1911, to April 3, 1911,
that I last saw him alive on " 2, 1911,
and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Proas abscess(Duration) 3 yrs. 2 mos. 1 ds.Contributory
(SECONDARY)
(Duration) ____ yrs. ____ mos. ____ ds.(Signed) J. J. Mackey M. D.
April 9, 1911 (Address) Odessa Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted
If not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Odessa Cem.DATE OF BURIAL 4/14, 1911UNDERTAKER L. C. HusmanADDRESS Odessa.Original file, date MAY 9, 1911

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)