

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

33374

File No. _____
Registered No. 219
St. _____ Ward _____

1. PLACE OF DEATH

County Cole Registration District No. 213
Township _____ Primary Registration District No. 2014
City Jefferson City (No. _____) St. _____ Ward _____

2. FULL NAME

Ruelle E Parkes
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jos M Parkes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 30 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 10 9

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Athens Co
(STATE OR COUNTRY) Ohio

10. NAME OF FATHER Henry Breele Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Amanda Mel...

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

14. INFORMANT Jos M Parkes
(Address) Daughters

15. FILE NO. 1030, 19 29 St Bedford
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 9th 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1929, to Oct 9 1929, that I last saw him alive on 9th 1929, and that death occurred, on the date stated above, at 12:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cholelithiasis 17th
12:30

CONTRIBUTORY (SECONDARY) Abuse of eye blade
(duration) 2 yrs. 2 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Oct 9-29

WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS Typical operation
(Signed) [Signature] M. D.

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
Jefferson City Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hippisville DATE OF BURIAL 10-13 1929

20. UNDERTAKER N. A. Meier ADDRESS Bonithon

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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10/10/29

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22-23-25

PARENTS

