

APR 30 1930

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

Do not use this space.

5801

1. PLACE OF DEATH

County New Madrid Registration District No. 605
Township Como Primary Registration District No. 5804
City (No) _____ St. _____ Ward _____

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

2. FULL NAME

James Thomas Parks
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF Fannie Seelinger
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 28-1861
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 5 5

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pulaska Tenn.

10. NAME OF FATHER Aron Parks
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pulaska Tenn.
12. MAIDEN NAME OF MOTHER Ann Mc Nice
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Pulaska Tenn.

14. INFORMANT J. A. Parks
(Address) Dochery Miss.

15. FILE NO. 2-4 19 30 Mrs C. S. Blackman REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 3rd. 1930
17. I HEREBY CERTIFY, That I attended deceased from August 5th 1929, to Feb 13th 1930 that I last saw him alive on Feb 2nd 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic nephritis
131
11/12 (duration) 5 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Pulmonary Edema
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at home
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS clinical symptoms
(Signed) S. E. Mitchell M. D.
2-4 19 30 (Address) Malden Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Malden, Mo. DATE OF BURIAL 2-5 1930

20. UNDERTAKER W. L. Gray ADDRESS Malden

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

