

JUL 25 1930

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

20386

1. PLACE OF DEATH

County Pike
 Township Current River
 City Lincoln (Name)

Registration District No. 712
 Primary Registration District No. 5986

File No. 10
 Registered No. 969
 St. _____ Ward _____

2. FULL NAME

Simon O. Parks Jr.

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)

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

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

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

Sallie Parks

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

4-14-1894

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
 day, _____ hrs.
 or _____ min.

56

2

15

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Simon O. Parks Sr.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Priscilla Laco

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

14.

INFORMANT

(Address)

Wiley R. Parks
OTM Park

15.

FILED

7-2, 1931 E. W. Johnston

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

6-27-1930

17.

I HEREBY CERTIFY, That I attended deceased from _____

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____, and that
 death occurred, on the date stated above, at _____ a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis

23 yr

(duration) 4 yrs. _____ mos. _____ ds.

CONTRIBUTORY

(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

W. R. Prater (Coroner)

6-28, 1930

(Address)

Doniphan - 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

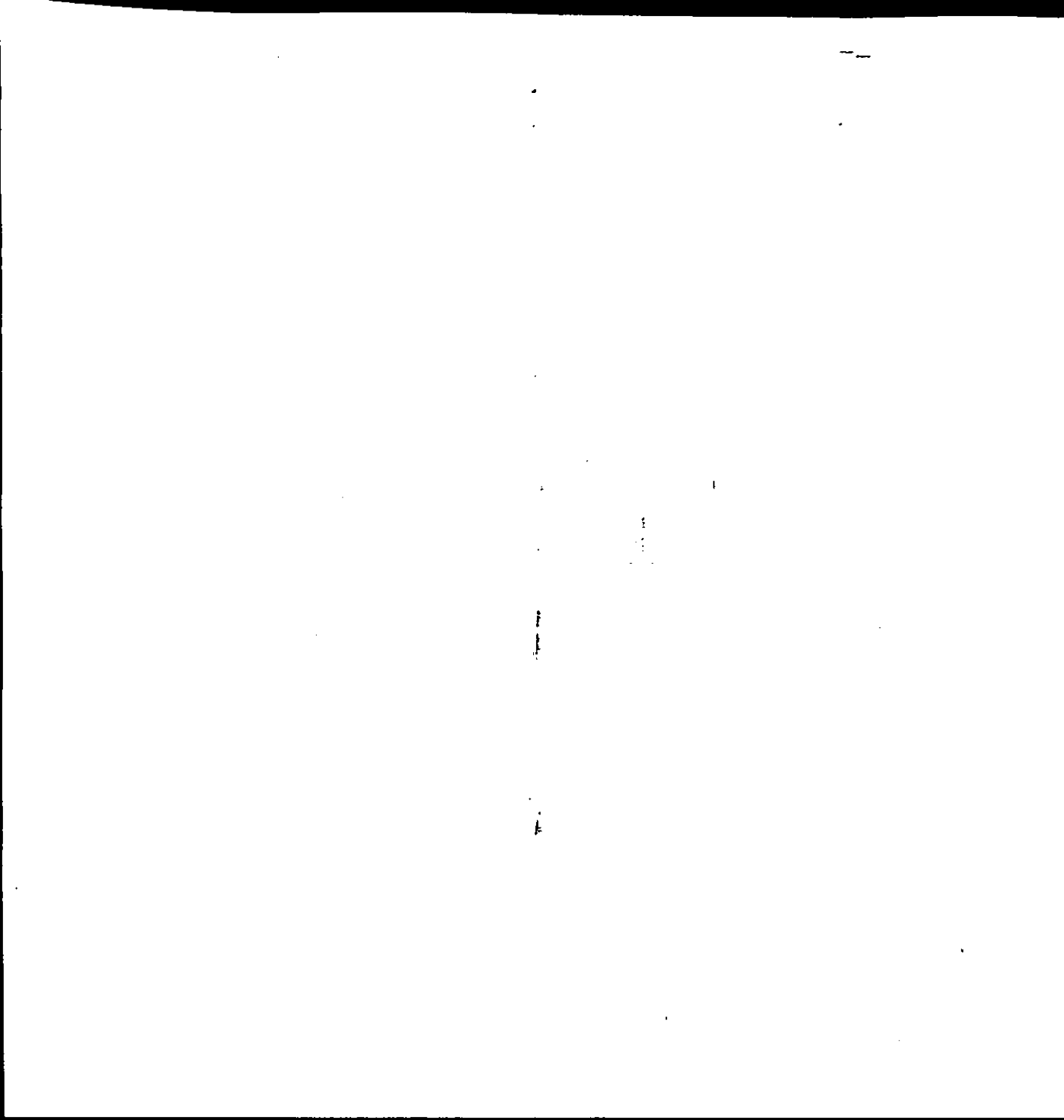
19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pike Registration District No. 750 File No.
Township Chapin River Primary Registration District No. 5986 Registered No.
City (No.) St. Ward)

2. FULL NAME

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
(Address)

15. FILED 7/2 30 E. A. Johnston.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 27 19 30

17. I HEREBY CERTIFY That I attended deceased from 19....., 19.....
that I last saw h..... alive on 19....., and that
death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Cornish Cemetery 6/28 1930

20. UNDERTAKER

Family Cornish, Mo

SUPPLEMENTARY

PARENTS

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

S-20386