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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 13 1939 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33948

Registration District No. 1003 Primary Registration District No. Registrar's No. 8486

1. PLACE OF DEATH:

(a) County ~~[illegible]~~ 2

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6543 Hancock
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 8

(c) City or town St. Louis 3
(If outside city or town limits, write "RURAL")

(d) Street No. 6543 Hancock
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Amanda Parks 620

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Milton Parks

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. 9, 1861 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
78	7	22	hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Newton P. Ritter
13. Birthplace (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Paralee Dunham
15. Birthplace (City, town, or county) N. Car. (State or foreign country)

16. (a) Informant's own signature Newton Parks
(b) Address 6543 Hancock

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Farmington, Mo.

18. (a) Signature of funeral director Jay B. Smith
(b) Address 7456 Manchester

19. (a) OCT 3 1939 (Date received local registrar) J. F. Bradbeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1
year 1939 hour 11 minute 25 P. M.

21. I hereby certify that I attended the deceased from January 7, 1939, to Oct. 1, 1939;
that I last saw her alive on Oct. 1, 1939;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremic Coma with Cardiac Failure	
Due to Nephritis, Chr. Interstitial	
Due to 59	
Other conditions Diabetes & Senility (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Joseph F. Trigg (M. D. or other) M.D.
Address 504 N. Grand Blvd Date signed 10/3/39

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4029

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.