

FILED APR 2 1940

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

11091
Do not use this space.

1. PLACE OF DEATH

(a) County HENRY Registration District No. 347
(b) Township Bethlem Primary Registration District No. 5489A Registered No. _____
(c) City Brownington (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Ernest Parks St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lillian Parks
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 19 - 1891
7. AGE YEARS 59 MONTHS 0 DAYS 12 IF LESS than 1 day,hrs. ormin.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. FARMER
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Gages (STATE OR COUNTRY) MISSOURI

13. NAME William A. Parks
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

15. MAIDEN NAME Mary Susan Deatherage
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

17. INFORMANT (ADDRESS) Ward Parks Brownington mo. R. #2.

18. BURIAL, CREMATION, OR REMAINS PLACED Good Hope Cem. DATE 3-7-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) _____

20. FILED 3-9 1940 Dr. J. P. Hampton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-1 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 29 1940 to March 1 1940
I last saw him alive on March 1 1940 Death is said to have occurred on the date stated above, at 4:30 p.m.
The principal cause of death and related causes of importance were as follows:

Hypostatic pneumonia Date of onset 2-3 days previous

Other contributory causes of importance: Chronic myocarditis Unknown

Name of operation none Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____ (Signed) S. B. Hughes M. D.
(Address) Clinton, Mo.

938c

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.....

P. O. Address.....

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

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

MO 2B
2-21-40
I X22559

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11091

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. Berry

Primary Registration District No. 3489

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Berry

(b) City or town Bethlehem Mo
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Ernest Parks

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: _____ (Month) (Day) (Year)

8. AGE: Years 59 Months 0 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 1 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw him _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death: hypostatic pneumonia
lobar pneumonia

Due to _____

Due to _____

Other conditions: _____ (include pregnancy within 3 months of death)

Major findings: Chronic Myocarditis

Of operations _____

Of autopsy _____

Duration 23 days

Physician Walt

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature S. B. Hughes (M. D. or other) _____

Address Clinton Mo Date signed _____

SUPPLEMENTARY

1940

S-11091