

3. No. 2
-11-10-39
FILED
NOV 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35851

State File No. _____

NOV 25 1940

566

Registration District No. _____

Primary Registration District No. 5762

Registrar's No. 137

1. PLACE OF DEATH: Mississippi, Mo

(a) County: Mississippi, Mo
(b) City or town: Charleston, Mo
(c) Name of hospital or institution: Rural
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution: 2
In this community: 75 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME: WILLIAM FRANKLIN PARKS

3. (b) If veteran, name war: ✓ 3. (c) Social Security No.: None

4. Sex: M 5. Color or race: W. 6. (a) Single, widowed, married, divorced: Single

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

7. Birth date of deceased: May 14th 1865
(Month) (Day) (Year)

8. AGE: Years: 75 Months: 4 Days: 24 If less than one day: _____ hr. _____ min.

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

10. Usual occupation: Laborer

11. Industry or business: Unknown

12. Name: Unknown

13. Birthplace: Unknown
(City, town, or county) (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. J. Smith

(b) Address: 6 Charleston, Mo

17. (a) Burial (b) Date thereof: Oct 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Oak Grove

18. (e) Signature of funeral director: James Shelby

(b) Address: East Prairie, Mo

19. (a) 10-7-40 (b) F. D. Vernon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Mississippi
(c) City or town: Charleston, Mo
(If outside city or town limits, write "RURAL")
(d) Street No.: Charleston Rd
(If rural, give location)
(e) If foreign born, how long in U. S. A.: Rural years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct day: 6, year: 1940 hour: 8 minute: 9 M.

21. I hereby certify that I attended the deceased from: Sept 19, 1940 to: Oct 6, 1940
that I last saw him alive on: Oct 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial insufficiency Duration: 1 month

Due to: Arteriosclerosis
Chronic nephritis

Other conditions: 121
(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? 745
While at work? _____ (Specify type of place) (e) Means of injury: _____

23. Signature: William L. Blawie (M. D. or other) MD

Address: Charleston, Mo Date signed: 10-7-40

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

Director

RECEIVED

District Health Officer No.

District File Number 1140-16

Date Filed 10/6/40

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.