

FILED AUG 7 1943 100

Registration District No. \_\_\_\_\_

Primary Registration District No. 3018

Registrar's No. 136

1. PLACE OF DEATH:

(a) County De Witt

(b) City or town Salem

(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

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

In this community 2 years (Specify whether)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Reynolds

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James L. Parks

3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_

3. (c) Social Security No. 4

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11  
year 1943 hour \_\_\_\_\_ minute 30 P.M.

21. I hereby certify that I attended the deceased from 5-20-43, 19, to 7-11-43, 19,  
that I last saw h alive on 7-10-43, 19,  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

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

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

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased July 24 - 1899  
(Month) (Day) (Year)

Immediate cause of death Pulmonary tuberculosis apparently 6 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day

43 11 16 hr. min.

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

10. Usual occupation Farmer

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name John F. Parks

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name Margaret Miner

15. Birthplace Reynolds Mo (City, town, or county) (State or foreign country)

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 John D. Spencer (M. D. or other) D.O.  
Address Salem, Mo Date signed 7-13-43

16. (a) Informant Lela Parks

(b) Address Salem

17. (a) Buried (b) Date thereof 7-12-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greeley Mo

18. (a) Signature of funeral director Carl Spencer

(b) Address Salem

19. (a) 7-13-43 (b) John D. Spencer  
(Date received local registrar) (Registrar's signature)

1177

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

RECEIVED

District Health Officer No. 5.

District File Number 843472

Date Filed 8-5-43

APR 22 1955

**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 Carl H. Jensen

Licensed Embalmer No. 2370

P. O. Address Jensen M.

**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, fact should be so stated above.**