

X28390

Registration District No. 37

Primary Registration District No. 5509

227

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Deer Creek Twp  
(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 \_\_\_\_\_  
years, months or days 92 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry  
(c) City or town Calhoun Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No. Deer Creek Twp  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2  
year 1943 hour 7 minute 30 P.M.  
21. I hereby certify that I attended the deceased from 1939  
to \_\_\_\_\_  
that I last saw him alive on Dec 1  
and that death occurred on the date and hour stated above.

Immediate cause of death

Paralysis

Due to

Old age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

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

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)

\_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Dr D A Pollard (M.D. or other) \_\_\_\_\_

Address Calhoun Mo Date signed 12/3/43

Duration

4 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Milton B. Parks

3. (b) If veteran, name war No 3. (c) Social Security No. 25

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased March 1 1951

8. AGE:	Years	Months	Days	If less than one day
	<u>92</u>	<u>9</u>		hr. _____ min. _____

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

10. Usual occupation Farmer

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

12. Name John Parks

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

14. Maiden name Jane Roberts Giddings

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

16. (a) Informant Gene Jones

(b) Address Calhoun Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Drakes Chapel

18. (a) Signature of funeral director J A Halsey

(b) Address Calhoun Mo

19. (a) Dec 3 1943 (Date received local registrar) (b) Georgia Kitchey (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File No.

12-43-145-0

Date Filed

1-6-44

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**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 myself  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*J. A. Housey*

Licensed Embalmer No.

3502

P. O. Address

*Calhoun Mo.*

**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.**