

No. 2
Pg. 43
17-39
337823

Registration District No. 230

Primary Registration District No. 4451

Registrar's No.

1. PLACE OF DEATH:

(a) County SCOTT

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

(c) Name of hospital or institution: NONE
(If not in hospital or institution, write street number or location)

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

In this community 30 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County SCOTT 100

(c) City or town FORNFEELT 20
(If outside city or town limits, write "RURAL")

(d) Street No. NONE (If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME JAMES PARKS

(b) If veteran, name war No

(c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 1
year 1948 hour 6:30 minute A M.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife LIEH MACDONALD PARKS

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

7. Birth date of deceased SEPT. 29 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from October 15 1948 to April 30 1948
that I last saw him alive on April 30 1948
and that death occurred on the date and hour stated above.

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

82 7 2 - hr. - min.

Immediate cause of death Respiratory failure

Due to Carcinoma

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

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation WATCHMAN - FLY - WALKER

11. Industry or business FORNFEELT BOX FACTORY

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

MOTHER FATHER { 12. Name JASPER NEWTON PARKS

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

14. Maiden name UNKNOWN OSBORNE

15. Birthplace UNKNOWN ILLINOIS
(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? _____

16. (a) Informant Mrs. Edith Parks Goodman

(b) Address Hemin, Illinois

17. (a) BURIAL (b) Date thereof MAY - 2 - 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LIGHTNER CEM. (ILLMO)

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature Benton Wilson, D.O. (M. D. or other) D.O.
Address Fornfelt, Mo. Date signed May 1, 1948

18. (a) Signature of funeral director E.C. Bisplinghoff

(b) Address Illmo, Missouri

19. (a) May 2 - 1948 (Date received local registrar)

237 (Registrar's signature)

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

RECEIVED

District Health Office No. 7

District File Number 548-60

Date Filed 5-10-48

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 Jack I. Burnett
Licensed Embalmer No. 4473
P. O. Address Chaffee, Missouri

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 0

Registration District No. 230

Primary Registration District No. 4485

1. PLACE OF DEATH: Scott Jansfelt

(a) County.....
 (b) City or town.....
 (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.....
 years, months or days)

3. (a) PRINT FULL NAME JAMES PARKH

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 wid
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Sept 29 1948
 (Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 20
 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

19. (a) (Date received local registrar) (b) (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) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 1948 Year 1948 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from..... 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.....

Due to Prostatic Carcinoma

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)
 (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

PHYSICIAN

 Underline the cause to which death should be charged statistically.

S-15146