S. No. 300
M—10-47
v. 5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 22 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 16469

Registrar's No. 1981

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 7 Days (Specify whether years, months or days)

In this community: 7 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Iowa (b) County: Taylor 999

(c) City or town: Gravity City 13
(If outside city or town limits, write "RURAL")

(d) Street No.: 0
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 21

If yes, name country:

3. (a) PRINT FULL NAME: PARKS, LOWELL E.

3. (b) If veteran, name war: No.

3. (c) Social Security No.: unknown

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: No

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

7. Birth date of deceased: 2 (Month) 12 (Day) 1929 (Year)

8. AGE: Years 19 | Months 2 | Days 26 | If less than one day: hr. min.

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

10. Usual occupation: Student

11. Industry or business:

FATHER
12. Name: Estele Parks
13. Birthplace: Gravity, Iowa (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Vesta Pace
15. Birthplace: Taylor Co. (City, town, or county) Ia. (State or foreign country)

16. (a) Informant: Mrs. Estele Parks
(b) Address: Gravity Ia.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5/9/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Bedford, Ia.

18. (a) Signature of funeral director: John P. Sheil
(b) Address: K. C. Mo.

19. (a) 5-9-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 8 year 48 hour minute M.

21. I hereby certify that I attended the deceased from May 1, 1948 to 5-8, 1948 that I last saw h. alive on 8 May 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Intraventricular hemorrhage	
Due to: Cerebellar Brain Tumor	
Other conditions: Malignant (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 54 B
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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: H. Carmichael Jr. (M. D. or other)
Address: 320 W 47th Date signed: 9 May

(Licensed Embalmer's Statement on Reverse Side)

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 Charles E. Mayfield, Registered Apprentice No. #18, working under my personal supervision.

Signed John D. Sheel

Licensed Embalmer No. 3625

P. O. Address St. Louis, 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.