

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

35591

State File No. _____

Registrar's No. 280

FILED NOV. 19 1948

Registration District No. 38

Primary Registration District No. 3006

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

1. PLACE OF DEATH:

(a) County Boone
 (b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
14 PARIS Ct. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Boone 10
 (c) City or town Columbia 2
(If outside city or town limits, write "RURAL")
 (d) Street No. 14 Paris Ct. 4
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MIRIAM PARK

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W 2
 6. (b) Name of husband or wife J. E. Park 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 11 29 1874
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Union City Tenn. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER { 12. Name Dr. C.P. Glover
 { 13. Birthplace _____ Ky. 1
(City, town, or county) (State or foreign country)
 { 14. Maiden name Kathryn Norrid
 { 15. Birthplace _____ Tenn. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J.D. Jonakin

(b) Address 14 Paris Ct.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11 8 48
(Month) (Day) (Year)

(c) Place: burial or cremation Union City, Tenn.

18. (a) Signature of funeral director Parbes Funeral Service

(b) Address 18 N. 107 Columbia, Mo.

19. (a) Nov 8 1948 (Date received local registrar) (b) Mrs. R.E. Palmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7 year 1948 hour 10 minute 20 a. M.

21. I hereby certify that I attended the deceased from _____, 1947, to Nov 7 - 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Sepsis Duration 2 d

Due to Pressure sores hip + back 2 mo

Due to Senility 1 yr

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

Major findings: Of operations 2/4 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? _____

While at work? _____ (Specify type of place) Means of injury 0

23. Signature Paul D. Duetrich (M. D. or other) 0
 Address Chap. Bldg. Columbia, Mo. Date signed Nov 7 48

RECEIVED
District Health Officer No. 9,
District File Number
NOV 18 1948
Date Filed

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 Tom M. Harg
Licensed Embalmer No. 4063
P. O. Address Columbia 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.