

FILED MAY 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13716

1940
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. <u>124</u>		REG. DIST. NO. <u>316</u>		PRIMARY REG. DIST. NO. <u>6074</u>		Registrar's No. <u>162</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Dezloge</u>		c. LENGTH OF STAY (in this place) <u>094-2</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Dezloge</u>		d. STREET ADDRESS (If rural give location) <u>406 Poe</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Hospital</u>				d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>406 Poe</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mr. Joseph William</u>		b. (Middle) <u>Pinkney</u>		c. (Last) <u>Gabriel Parks</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 25 - 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White-Cauc</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 10/9/1948</u>	8. DATE OF BIRTH <u>July 19-1878</u>		9. AGE (In years last birthday) <u>72-9-6</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital No. 4, Joplin, Mo. Near Charleston, Mo.</u>		11. BIRTHPLACE (State or foreign country) <u>U</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Mr. William S. Parks</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Magee</u>		14. NAME OF HUSBAND OR WIFE <u>Oliver Belle Parks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-10-5863</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Marshal C. Parks (Son) Dezloge, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerotic cardiovascular disease</u>				unknown	
		DUE TO (c) <u>Cerebral hemorrhage (3) in last 4 mos. 3/31</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1951</u> , to <u>4-25, 1951</u> , that I last saw the deceased alive on <u>4-25, 1951</u> , and that death occurred at <u>4 p</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>J. L. Foster</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Dezloge Mo</u>		23c. DATE SIGNED <u>4-29-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 29-1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Bonne Terre Mo</u>	
DATE REC'D BY LOCAL REG. <u>May 3, 1951</u>		REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alvin W. Hood</u>		ADDRESS <u>303 Centre St. St. Francois, Mo.</u>	

File No. _____
DISTRICT HEALTH OFFICE No. 4

MAY 7 1951

RECEIVED

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Alvin W. Hood

Signed
Student Embalmer

Licensed Embalmer No. 2780

P. O. Address 303 Chestnut St. Philadelphia, Pa.

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.