

FILED NOV 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39552

State File No. _____

318

1003

9824

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis		2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 5400 Arsenal			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) LIZZIE	b. (Middle)	c. (Last) PARKS	Nov. 4, 1951		

5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 10, 1868	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Montgomery, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Creed Taylor	13b. MOTHER'S MAIDEN NAME Ann Robinson	14. NAME OF HUSBAND OR WIFE Benj. Parks
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Jas. Taylor	ADDRESS 4055a Page
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease		
	ANTECEDENT CAUSES DUE TO (b) Sepsis from decubiti DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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 4200
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22. I hereby certify that I attended the deceased from Jan. 1, 1951, to Nov. 4, 1951, that I last saw the deceased alive on Nov. 4, 1951, and that death occurred at 9:15p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Mary Jean Murphy	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 11/5/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-7-51	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE RECD BY LOCAL REG. NOV 6 1951	REGISTRAR'S SIGNATURE Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Russell Undertaking Co.	ADDRESS 2732 Pine S
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

I hereby certify

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

James A. Carter

Signed.....
Student Embalmer

Licensed Embalmer No. *4680*

P. O. Address *4923 Sulphur*

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.