

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25060

State File No. ....

FILED JUL 26 1954

318

1003

6284

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MO.</b>  c. LENGTH OF STAY (In this place) <b>2 DAYS</b>  d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>  c. CITY OR TOWN <b>Woodriver</b>  d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>  e. STREET ADDRESS (If rural, give location) <b>812<sup>2</sup> 8</b>	
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<b>3. NAME OF DECEASED</b> (Type or Print) <b>Guy Clay Parks</b> a. (First) <b>Guy</b> b. (Middle) <b>Clay</b> c. (Last) <b>Parks</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>July 10, 1954</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Aug. 18, 1890</b>	<b>9. AGE</b> (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Drugs</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) / <b>Anna, Illinois,</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>

<b>13a. FATHER'S NAME</b> <b>George Clay Parks</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Carrie Rich</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Margaret Parks</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>No.</b>	<b>16. SOCIAL SECURITY NO.</b> <b>Nil.</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <b>Margaret Parks, Anna, Illinois.</b>

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)	<b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>STATUS ASTHMATICUS &amp; ATELECTASIS</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>BRONCHIAL ASTHMA</b>  DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>  <b>30 YRS.</b>
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <b>241X</b>	

22. I hereby certify that I attended the deceased from July 8, 1954, to July 10, 1954, that I last saw the deceased alive on July 10, 1954, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

<b>23a. SIGNATURE</b> <i>[Signature]</i>	(Degree or title) <b>M.D.</b>	<b>23b. ADDRESS</b> <b>BARNES HOSPITAL</b>	<b>23c. DATE SIGNED</b> <b>7/10/54</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>24b. DATE</b> <b>7-11-54</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Anna Cemetery</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Anna, Illinois,</b>

<b>DATE REC'D BY LOCAL REG.</b> <b>Jul 12 1954</b>	<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Albert H. Hoppe 4700 Washington.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

**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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Paul A. Wachter*.....

Licensed Embalmer No. *478*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.