

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **31322**
Registrar's No. **7812**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. LENGTH OF STAY (in this place) 24 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Frank		b. (Middle) E.	
c. (Last) Parks		4. DATE OF DEATH (Month) (Day) (Year) Aug. 30, 1955	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 10-24-1883
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) druggist		10b. KIND OF BUSINESS OR INDUSTRY Retail Drug	
11. BIRTHPLACE (City and State or Foreign Country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Robert T. Parks		13b. MOTHER'S MAIDEN NAME Jane Irwin	
14. NAME OF HUSBAND OR WIFE Pearl Parks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT'S SIGNATURE OR NAME Pearl Parks, Marion, Ill.		ADDRESS	
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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DUE TO (b) Laennec's Cirrhosis of Liver		Yrs.	
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 581.1	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 Aug. 6, 1955 , to Aug. 30, 1955 , that I last saw the deceased alive on Aug. 30, 1955 and that death occurred at 10:22 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) C. J. Vermillion, M.D.		23b. ADDRESS BARNES HOSPITAL	
23c. DATE SIGNED 8/30/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 8-31-55	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Marion, Ill.	
DATE REC'D BY LOCAL REG. SEP 6 1955		REGISTRAR'S SIGNATURE Wilson-Frick	
25. FUNERAL DIRECTOR'S SIGNATURE Wilson-Frick		ADDRESS Marion, Ill.	

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 *Ronald O. Yohube*.....

Licensed Embalmer No. *391*.....

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.