

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35474

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 2369

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>	
b. CITY OR TOWN <b>Richmond Heights</b>		c. CITY OR TOWN <b>Ilasko</b>	
c. LENGTH OF STAY (In this place) <b>1 wk.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>Box No. 93</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Richard</b> b. (Middle) <b>Lee</b> c. (Last) <b>Parks</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>October 14, 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>Jan 24, 1954</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None - Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) <b>1</b> IF UNDER 1 YEAR Months <b>8</b> Days <b>20</b> IF UNDER 12 HRS. Hours <b>20</b> Min.
11. BIRTHPLACE (City and State or Foreign Country) <b>Hannibal, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Daniel D. Parks</b>		13b. MOTHER'S MAIDEN NAME <b>Eileene Stringer</b>	14. NAME OF HUSBAND OR WIFE <b>Nil NONE</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>Nil</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Daniel D. Parks, Ilasko, Missouri.</b>
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) <b>Acute Leukemia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>2093</b>	
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) m.	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 <b>10-7, 1955</b> , to <b>10-14, 1955</b> , that I last saw the deceased alive on <b>10-14, 1955</b> , and that death occurred at <b>9:00</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>John L. Davis MD</b> (Degree or title)		23b. ADDRESS <b>3511 Central</b>	23c. DATE SIGNED <b>10-15-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10-17-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Hannibal, Missouri.</b>
DATE REC'D BY LOCAL REG. <b>10-15-55</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Dombke MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington</b>	

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 *Robert M Murray*.....

Licensed Embalmer No. *37498*.....

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.**