

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034171

FILED VS SEP 21 1959

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's

8248

MAILED

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Length of stay in 1b 45 Yrs. | | c. CITY OR TOWN ST. LOUIS | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2931 Eads | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 2931 Eads | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last NETTIE EDITH PARKS | | | | 4. DATE OF DEATH Month Day Year September 7, 1959 | | | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4/27/87 | 9. AGE (last birthday) 72 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Minister | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | |
| 13a. FATHER'S NAME William Boyet | | | 13b. MOTHER'S MAIDEN NAME Ida Buckener | | | 14. NAME OF HUSBAND OR WIFE Thomas N. Park | | | | | |
| 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. 494-01-3405 | | 17. INFORMANT Address (22) Thomas W. Parks, 208 Frieda | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Cardiac Compensation DUE TO (c) Pericarditis + chronic INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years 3 years. | | | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Tachy cardiac - pericardial adhesion | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Sept 30, 1956 to July 1, 1959 and last saw her on July 1, 1959 Death occurred at 5:15 pm on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) John V Lawrence | | | | 22b. ADDRESS 9720 Washington Ave St. Louis 9-7-59 | | | | 22c. DATE SIGNED | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE 9/10/1959 | 23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Ceme. | | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | | | | | |
| 24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette Ave. | | | | 25. DATE RECD. BY LOCAL REG. SEP 8'59 | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 James R. Chapman
Licensed Embalmer No. 24552
P. O. Address St. Javis,

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.