URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 28 1960 318 1003 =60-044047

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 11226 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 11 Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cardinal Glennon Hospital — Inside Limits Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St Louis
c. CITY OR TOWN: Crestwood — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 8738 Townhill Drive — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Richard Middle: Patrick Last: Parks
4. DATE OF DEATH: Month Day Year: November 20, 1960
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. Married [ ] Never Married [X] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 3/17/1960
9. AGE (last birthday): 8 months — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Robert M. Parks
13b. MOTHER'S MAIDEN NAME: Ruth Brockhaus
14. NAME OF HUSBAND OR WIFE: Never married
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert M. Parks — Address: See #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	8 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Paralysis phrenic Nerves	9 days
DUE TO (c)	Mediastinal Cystic Hygroma	7½ mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Multiple Lymphangiomata 228x

PART III. If - deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 11-9-60, to 11-20-60 and last saw him alive on 11-20-60
Death occurred at 8:43 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J Eugene Lewis Jr MD
22b. ADDRESS: 634 N. Grand St Louis 3
22c. DATE SIGNED: 11-21

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11/22/1960
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR: Hoffmeister Colonial Mortuary — ADDRESS: 6464 Chippewa Street St. Louis, Missouri
25. DATE RECD. BY LOCAL REG.: NOV 22 1960
26. REGISTRAR'S SIGNATURE: Noel Smith, M.D.

DOCUMENT

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed [illegible]

Licensed Embalmer No. 476

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.