MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

25326

1. PLACE OF DEATH
County New Madrid Registration District No. 605 File No.
Township Como Primary Registration District No. 5804 Registered No. 605
City ~~Parma~~ (No. St. Ward)

2. FULL NAME Wm Parks
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) /

7. AGE: About 55 yr — YEARS | MONTHS: D.K | DAYS: D.K | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED 94A
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (~~CITY OR TOWN~~) (STATE OR COUNTRY): Mississipi

PARENTS
10. NAME OF FATHER: D.K
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): D.K
12. MAIDEN NAME OF MOTHER: D.K
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): D.K

14. INFORMANT (Address): Leo King

15. FILED 7-24 1929 Mrs. C.S. Blackman By Mrs Steven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 24 1929

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at about 6 o'clock

THE CAUSE OF DEATH* WAS AS FOLLOWS: Dropped Dead Died with her medical attendant Death probably caused By Angina Pectoris (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Not Known
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) Dr. O'Bannon, M.D.
New Madrid, 19 29 (Address) Mrs. C.S. Blackman Mrs. U.B. Stevenson

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Shady Grove Cemetery | DATE OF BURIAL: July 25 1929

20. UNDERTAKER: Stoddard Co. None C.M. Hill | ADDRESS: Cilbourn Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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