

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

9275
 Do not use this space.
3040

REC'D APR 12 1939

791
 1003

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No.....
 (c) City St. Louis, Mo. (d) Street No. City Infirmery St.
 (e) Length of residence in city or town where death occurred Life yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

620 Matt Parks,
 (a) Residence, No. 5800 Arsenal St. St. 13 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unk - 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
83 (about) X X

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. No Occupation
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

FATHER 13. NAME John Parks

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown.

MOTHER 15. MAIDEN NAME Catherine McKay,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown.

17. INFORMANT (ADDRESS) E. Holony, 5800 Arsenal St.

18. BURIAL, CREMATION, OR REMOVAL Washington DATE 3/16/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wrights 3800

20. FILED MAR 31 1939 J.B. Prudick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from September 23, 1937 to March 7, 1939

I last saw him alive on March 7, 1939 Death is said to have occurred on the date stated above, at 3:45 P.M.
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Date of onset

Other contributory causes of importance:

Name of operation Date of.....
 What test confirmed diagnosis? A.P.P. Was there an autopsy? no.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury....., 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no.
 If so, specify William Sapsin, M.D.
 (Address) 5600 Arsenal St.

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

K. 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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.