

JAN 11 1940

Registration District No. 347

Primary Registration District No. 5501A

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Rural Leeuville Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 38 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2 mi Clinton  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME Martha A Parks  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 12 day 15  
year 1939 hour 10 minute 50 A. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 5 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July, 1939, to Dec 1, 1939;  
that I last saw her alive on Oct 1, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Sercoma uterina Duration 271  
Due to \_\_\_\_\_  
Due to 48

8. AGE: Years 72 Months 6 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Calhoun Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Labare Parks 9

13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Parks

15. Birthplace Clinton Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marrin Parks

(b) Address Clinton Mo

17. (a) Funeral (b) Date thereof 12-16-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parks Chapel

18. (a) Signature of funeral director Fred C. W. Robinson

(b) Address Clinton Mo 315

19. (a) 12-23-39 (b) Dr. J. N. Vanhook  
(Date received local registrar) (Registrar's signature)

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. D. Walker (M. D. or other) MD

Address Clinton Mo Date signed 12-14-39

PHYSICIAN  
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information furnished hereon 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.

Rev. 5-17-39  
1 x1511

RECEIVED

District Health Officer No. 7,

District File Number 1-40-67

Date Filed 1-9-40

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**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. 2478

P. O. Address Clinton M.

**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.**