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NOV 20 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36410 ✓

Registration District No. 784

Primary Registration District No. 111

State File No. _____

Registrar's No. 2074

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME WILLIAM S. PARK.

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Della Park. 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased September 25, 1874.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>1</u>	<u>9</u>	hr. _____ min. _____

9. Birthplace Chicago, Illinois.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired.

11. Industry or business Building Contractor

MOTHER FATHER { 12. Name Benjamin Park. 1

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

14. Maiden name Helen Cutting.

15. Birthplace Long Island New York.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Della Park.

(b) Address 6303 Bartmer Ave.

17. (a) Burial (b) Date thereof 11-6-1940.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.

(b) Address 5966-68 Easton Ave.

19. (a) NOV 5 1940 (b) R. M. Pleitsch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town University City,
(If outside city or town limits, write "RURAL")

(d) Street No. 6303 Bartmer Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 3rd.
year 1940 hour 4 minute A.M. M.

21. I hereby certify that I attended the deceased from June 1, 1930 to 11/3, 1940;
that I last saw him alive on 11-3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrus of brain

Due to _____
Due to 12/4/40

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations curious & liver
Of autopsy None

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence None

(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? None

While at work? None (a) Means of injury _____

23. Signature June 1940 (M. D. or other) 1940
Address 6125 Bartmer Date signed 11/4/40

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

Dr. Pierce Reilly.
6125 Bartmer Ave.
Hours 9.30 to 11 Am. 2 to 4 P.M.
Telephone Cabany 5187

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 3454

David C. Gibson

, Registered Apprentice No.

working under my personal supervision.

Signed

David C. Gibson

Licensed Embalmer No. 3454

P. O. Address 5966 Easton Court

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.

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State File No. 36410
Registrar's No. 2074

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 784

Primary Registration District No. 111

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

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Richmond Hills
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Marys Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME: Wm S. Park

3. (b) If veteran, name war: _____

3. (c) Social Security No.: _____

5. Color or race: Female W

6. (a) Single, widowed, married, divorced: in

6. (b) Name of husband or wife: _____

6. (c) Age of husband, or wife, if alive: _____ years

7. Birth date of deceased: _____ (Month) (Day) (Year)

8. AGE: Years 66 Months 1 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation: _____

11. Industry or business: _____

MOTHER FATHER { 12. Name: _____

{ 13. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name: _____

{ 15. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant: _____

(b) Address: _____

17. (a) _____ (b) Date thereof: _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation: _____

18. (a) Signature of funeral director: _____

(b) Address: _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: _____ (b) County: _____

(c) City or town: _____ (If outside city or town limits write "RURAL")

(d) Street No.: _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month Nov day 3 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: _____

Due to: _____

Due to: _____

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

PHYSICIAN: _____

Underline the cause to which death should be charged statistically.

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: W. J. [Signature] (M. D. or other)

Address: _____ signed

SUPPLEMENTAL COPY

