

No. 2
-1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 18 1941
791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 29795
Registrar's No. 7133

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST. LOUIS, MISSOURI
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 31 DAYS
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME PARKS, LOREN IVAN
3. (b) If veteran, name war Unknown
3. (c) Social Security No. 342-01-7368

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lula
6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased June 11 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 2 20 hr. min.

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

10. Usual occupation Coal Mining

11. Industry or business _____

12. Name Otis Parks

13. Birthplace Saline Co. / Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Jennie Moore

15. Birthplace Saline Co. / Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Lula Parke

(b) Address West Frankfort, Ill.

17. (a) Removal (b) Date thereof 9/3/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Frankfort, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. SEP 1941 (Date received local registrar) (b) J. Bredick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Franklin
(c) City or town West Frankfort
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
AUGUST. 31

20. DATE OF DEATH: Month AUGUST. 31 day _____
year 1941 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8/1/41 19 to 8/31/41 19;
that I last saw him alive on 8/31/41 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Bronchitis and atelectasis, left lower lobe
Duration _____

Due to Postoperative hemorrhage, tracheotomy and aspiration

Due to Toxic hepatitis? Cerebral vascular

Other conditions accident? cardiac failure

Major findings: Of operations Thyroidectomy

Of autopsy 638

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 Barnes Hospital (M. D. or other) O M.D.

Address _____ Date signed 8/31/41

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

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..... *G. W. Wilkinson*
Licensed Embalmer No..... *3575*

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, fact should be so stated above.