

FILED APR 17 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9999

Registration District No. 1

Primary Registration District No. 1

Registrar's No. 97

1. PLACE OF DEATH:

- (a) County Wade
 (b) City or town Kirksville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Community Nursing Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. 5 days
 (Specify whether years, months or days) 61 years

3. (a) PRINT FULL NAME

James M Parks

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male5. Color or race White6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

Alma Parks6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased

Aug 41880

(Year)

8. AGE:

Years

Months

Days

If less than one day

61718

hr. min.

9. Birthplace

Macon Co

(City, town, or county)

Mo

(State or foreign country)

10. Usual occupation

Carpenter

11. Industry or business

12. Name

James M Parks

13. Birthplace

Raleigh N. Carolina

(City, town, or county)

(State or foreign country)

14. Maiden name

Margaret Parker

15. Birthplace

Macon Co

(City, town, or county)

Mo

(State or foreign country)

16. (a) Informant's own signature

Clyde Parks

(b) Address

Macon Mo17. (a) burial

(Burial, cremation, or removal)

(b) Date thereof

Mar 24-42

(c) Place: burial or cremation

Baker Cemetery

18. (a) Signature of funeral director

Robert Skinner

(b) Address

Macon Mo19. (a) Mar. 24, 1942

(Date received local registrar)

Ma J. L. Wayne

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Macon
 (c) City or town Macon 061
 (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. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1942 hour 8 minute 05 A.M.

21. I hereby certify that I attended the deceased from

Feb 15, 1942, to March 22, 1942that I last saw him alive on March 22, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death

Congestive heart failure

Duration

Due to

Chronic myocarditis

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 M. T. Shetters (M.D. or other) D.O.Address Kirksville Date signed March 24 1942

RECEIVED

District Health Officer No. 10

District File Number 4-10-398

Date Filed APR 15 1948

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..... *Albert Skinner*

Licensed Embalmer No. 757

P. O. Address Moan Md

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.