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5-17-39
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAY 12 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13839

State File No.

Registration District No. 99 90

Primary Registration District No. 512+5134A

Registrar's No. 99

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Quilin 10th Block
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12
(c) City or town Quilin 0
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Carie Jane Parks

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 1. Color or race w
5. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. 2, 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 18 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Fred Parks
13. Birthplace Hawville, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Martha Ward
15. Birthplace unknown Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Father, Fred Parks
(b) Address Quilin, Mo.

17. (a) Burial (b) Date thereof Mar. 20, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Green Hill
Home cemetery

18. (a) Signature of funeral director None

(b) Address Friends

19. (a) 3-21-42 (b) Belle Tenney
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20
year 1942 hour 2:30 minute A. M.

21. I hereby certify that I attended the deceased from March 18
March 20, 1942 to March 20, 1942
that I last saw her alive on March 19, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death
Begins Pneumonia, both 3 day
Lungs

Due to L

Due to L

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

Major findings:
Of operations L

Of autopsy L

Duration
3 day
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) L

(b) Date of occurrence L

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

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

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

23. Signature Scott Coal (M. D. or other) 0

Address Quilin Mo Date signed 3/20-42

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

200

92

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2

District File Number 442-623

Date Filed 4-13-42

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 ^{no} not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13839

Registration District No.

Primary Registration District No. 5134a

Registrar's No.

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Dulin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler
(c) City or town Dulin
(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 _____

3. (a) PRINT FULL NAME

Carie G. Parks

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 21 - 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 20
Year 1948 Hour 2:00 minute 30 a.m.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death Broncho pneumonia

Due to flu

Due to _____
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?
_____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

3 dks

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

