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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 10 1942

Registration District No. 112

Primary Registration District No. 5432

Registrar's No. 31

3600

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

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution: Home in Stanton
(If not in hospital or institution, write street number or location)

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

In this community Lifetime
years, months or days

3. (a) PRINT FULL NAME ALFERD JAMES PARKS

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased May 6 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

65 6 18 hr. min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Eola B. Parks

13. Birthplace Franklin Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Melinda Thompson

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

16. (a) Informant Maggie A. Park

(b) Address Stanton Mo

17. (a) Burial (b) Date thereof 11-26-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanton Mo

18. (a) Signature of funeral director Robert Dent

(b) Address St. Clair Mo

19. (a) 11/25/1942 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town St. Clair
(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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24
year 1942 hour 2 minute 0 M.

21. I hereby certify that I attended the deceased from Nov 22, 1942, to Nov 24, 1942 that I last saw him alive on Nov 24, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Infarction

Due to Cor. Arteriosclerosis

Due to _____

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

Major findings: _____

Of operations 1318

Of autopsy _____

Duration

7 yrs

?

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 0

23. Signature W. H. Dent (M. D. or other) _____

Address St. Clair Mo Date signed 11/24

JAN 4 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.....

Geo. L. Heber

Licensed Embalmer No.....

3098

P. O. Address.....

Pacific, Me

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.

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21-41
29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37033

Registration District No. 114

Primary Registration District No. 5432

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Stamton
(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 _____
years, months or days)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

alfred James Parks

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced. m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

(Month) May

(Day) 6

(Year) _____

8. AGE:

Years 65

Months 6

Days _____

If less than one day _____ min.

9. Birthplace _____

(City, town, or county) MO.

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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) 11/25/42
(Date received local registrar)

(b) Hilbert Gilhaus
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____

year 1942

hour _____

minute _____

M. _____

21. I hereby certify that I attended the deceased from _____, 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 _____

Duration _____

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)

(b) 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 _____

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

SUPPLEMENTARY 4

