

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23355**
Registrar's No. **7022**

Registration District No. **318** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County *********
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4056 Washington Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **-----** (Specify whether years, months or days) **3 Years**

3. (a) PRINT FULL NAME **Carrie Parks**

3. (b) If veteran, name war **---** 3. (c) Social Security No. **487-24-3328**

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

6. (b) Name of husband or wife **Clarence Parks** 6. (c) Age of husband or wife if alive **29** years

7. Birth date of deceased **December 15 1916**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
26 7 16 hr. min.

9. Birthplace **Blytheville Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Maid**

11. Industry or business **Domestic service**

MOTHER FATHER { 12. Name **Scott**
13. Birthplace **Unavailable Unk. 9**
(City, town, or county) (State or foreign country)
14. Maiden name **Unavailable Unk.**
15. Birthplace **Unavailable Unk. 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Clarence Parks**
(b) Address **4056 Washington Ave. (rear)**

17. (a) **Burial** (b) Date thereof **8/4/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **Charles J. Gates**
(b) Address **4107 Finney Ave.**

19. (a) **AUG 3** (b) **J. F. Predeck**
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **-----**
(c) City or town **Saint Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4056 Washington Ave. (rear)**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **-----**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **1st**
year **1943** hour **8** minute **00** A. M.

21. I hereby certify that I attended the deceased from **Jan 31 - 43**
July 31, 19**43**, to **Aug 1**, 19**43**
that I last saw him alive on **July 1**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Septic Condition**
Due to **Septic Condition**

Due to **acute myocardial**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **30**
Of autopsy **U**

Duration
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 **J. F. Predeck** (M. D. or other) **D**
Address **2742 Franklin Ave.** Date signed **8/2/43**

Hurt

STATEMENT BY LICENSED EMBALMER

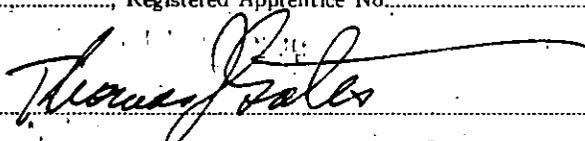
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates

Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. **4259**

P. O. Address **4107 Finney Ave.**

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 state above.