

FILED FEB 19 1945
Registration District No. 33

Primary Registration District No. 3010

Registrar's No. 13

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)
 In this community 1 month
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Harold Roscoe 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 Melba Sutton 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased August 15th 1909
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
35 4 29 hr. min.

9. Birthplace Crab Orchard Illinois
(City, town, or county) (State or foreign country)
 10. Usual occupation Independent Truck Driver

11. Industry or business _____
 12. Name Roscoe Parks
 13. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)
 14. Maiden name Etta Fife
 15. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Melba Parks
 (b) Address Cape Girardeau, Missouri
 17. (a) Removal (b) Date thereof 1-14-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Marion Illinois
 18. (a) Signature of funeral director L. L. Haman
 (b) Address Cape Girardeau, Missouri
 19. (a) 1-16-45 (b) F. W. Phelps
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
 (c) City or town Cape Girardeau 16
(If outside city or town limits, write "RURAL")
 (d) Street No. 330 South Middle Street 1
(If rural, give location)
 (e) Citizen of foreign country? No 4 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14th
 year 1945 hour 1 minute 50 A.M.
 21. I hereby certify that I attended the deceased from Jan 12, 1945, to Jan 14, 1945;
 that I last saw him alive on Jan 14, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death General peritonitis 3 days
 Due to Perforated gastric ulcer and perforated bowel (ileum)
 Due to ulcer - possibly carcinoma
 Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 Major findings: as above
 Of operations _____
 Of autopsy as above

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) (e) Means of injury _____
 23. Signature R. G. Ritter, M.D. (M. D. or other) _____
 Address Cape Girardeau, Mo. Date signed 1-14-45

MAR 2 1945

RECEIVED

District Health Officer No. 4
District File Number 245-217
Date filed 2-7-45

MAR -6 1945

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 not embalmed, fact should be so stated above.