

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

5790

FILED MAR 14 1945

Residence District No.

Primary Registration District No. 3011

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
N. Jefferson et al
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 years (Specify whether
In this community 20 years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME MARSHALL M. 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 Widowed

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

7. Birth date of deceased Aug. 28 1881
(Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Fleming Co. Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER

12. Name Octavus W. Parks

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Martina Ann Grimes

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Carrollton, Mo.

(b) Address Burial (b) Date thereof 2-6-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wakenda Cem.

18. (a) Signature of funeral director Standley Funeral Home

(b) Address Carrollton, Mo.

19. (a) 2-6-45 (b) Mrs James Rafferty
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll 17
(c) City or town Carrollton
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3
year 1945 hour 1 minute 45A. M.

21. I hereby certify that I attended the deceased from Nov. 7
1944 to Feb. 3 1945
that I last saw him alive on Feb. 3 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart Failure Duration 2 wks.

Due to Hypertension Jan.

Due to Chronic Nephritis Jan.

Other conditions Chronic Cholelithiasis
(Include pregnancy within 3 months of death)

Major findings:
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?

While at work? _____ (Specify type of place) (e) Means of Injury _____

23. Signature Frank A. Smith (M.D. or other) D.O.
Address 411 E. Main Carrollton Mo. Date signed 2/5/45

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

7
1
4

RECEIVED

District Health Officer No. 8,

File-Number

3-12-75

Filed

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

Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address

Carrollton, Mo

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.