

FILED DEC 13 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37082

State File No. ....

126

2000

Registrar's No. 1107

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>		c. CITY OR TOWN <b>Sarcoxie</b>	d. If residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>0420</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Francis</b> b. (Middle) <b>Samuel</b> c. (Last) <b>Parks</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 5 1954</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>Nov. 4 1867</b>		9. AGE (In years last birthday) <b>87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Lincoln Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>James Parks</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Jessie (Deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Geo Parks</b> ADDRESS <b>1325 Maryland</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Haemorrhage Cerebral &amp; Hemiplegia</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Senility</b>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Broncho Pneumonia</b>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>331X</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from **Nov 22, 1954**, to **Dec 5, 1954**, that I last saw the deceased alive on **Dec 4, 1954**, and that death occurred at **8:55 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. Norton W. ...</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>Springfield, Mo</b>		23c. DATE SIGNED <b>12-6-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Dec 8-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Sarcoxie Cem</b>	
24d. LOCATION (City, town, or county) <b>Sarcoxie Mo</b>		24e. (State)			

DATE REC'D BY LOCAL REG. <b>12-9-54</b>		REGISTRAR'S SIGNATURE <b>Edw. Williamson</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Jochant Sons</b> ADDRESS <b>Sarcoxie Mo</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 16 1954

DEC 21 1954

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 ....., Student Embalmer No. 716 working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed Wm R. Jackson

Licensed Embalmer No. 39

P. O. Address Lacey

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.