

FILED FEB 12 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **314**
Registrar's No. **131**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **4052**

| | | | |
|---|---|--|-------------|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Agency (town) | c. LENGTH OF STAY (in this place) 2 yrs. | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Agency | 1110 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION General Delivery | | d. STREET ADDRESS (If rural, give location) General Delivery | |

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|-------------------------------------|---------------------------|----------------------------|-------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) LEONARD | b. (Middle) WILLIAM | c. (Last) PARKER | 4. DATE OF DEATH (Month) (Day) (Year) |
| | | | | 1 1 1951 |

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|--------------------|-------------------------------|---|----------------------------------|---|-----------------------|----------------------|----------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 5-5-1874 | 9. AGE (In years last birthday) 76 | # UNDER 1 YEAR Months | # UNDER 4 HRS. Hours | # UNDER 15 MIN. Min. |
|--------------------|-------------------------------|---|----------------------------------|---|-----------------------|----------------------|----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Farm | 11. BIRTHPLACE (State or foreign country) White Cloud, Kansas / | 12. CITIZEN OF WHAT COUNTRY? USA |
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|---------------------------------------|--|--|
| 13a. FATHER'S NAME John Parker | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Sarah E. Parker |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Sarah E. Parker, Agency, Mo. | ADDRESS |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | 1 month |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension | | Unknown |
| | DUE TO (c) Arteriosclerosis | | Unknown |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Prostate | | Unknown | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) |
| | | 331X H |
| 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 **Dec. 2, 1950**, to **Jan. 1, 1951**, that I last saw the deceased alive on **Dec. 2, 1950**, and that death occurred at **3:50A.M.**, from the causes and on the date stated above.

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| 23a. SIGNATURE Allen Sherman MD | 23b. ADDRESS 600 Francis St. | 23c. DATE SIGNED 1-3-1951 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 1-3-1951 | 24c. NAME OF CEMETERY OR CREMATORY Leona, Kansas | 24d. LOCATION (City, town, or county) (State) Leona, Kansas |
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| DATE REC'D BY LOCAL REG. Feb 9, 1951 | REGISTRAR'S SIGNATURE Carl C. Casper | 25. FUNERAL DIRECTOR'S SIGNATURE John E. Casper | ADDRESS St. Joseph, Mo. |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *John E. Rupp*
Student Embalmer No.

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, 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.