

FILED JUN 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16086
2221

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 35 yrs.	c. CITY OR TOWN Kansas City
d. FULL NAME OF HOSPITAL OR INSTITUTION 3113 Brooklyn		STREET ADDRESS (If rural, give location) 3113 Brooklyn	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Thomas	b. (Middle) Bell	c. (Last) PARKER	(Month) May	(Day) 16,	(Year) 1954
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-6-84	9. AGE (in years last birthday) 69	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Painter		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and State or Foreign Country) Palmyra, Nebraska		12. COUNTRY OF WHAT CITIZENRY? USA

13a. FATHER'S NAME John H. Parker	13b. MOTHER'S MAIDEN NAME Elizabeth Bell	14. NAME OF HUSBAND OR WIFE Lavina J. Parker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW-1 500-14-8125	17. INFORMANT'S SIGNATURE OR NAME Mrs. Lavina Parker, 3113 Brooklyn, KC, Mo.

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		INTERVAL BETWEEN ONSET AND DEATH 4500
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Fracture Heart Cradle	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) natural	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) m.	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23. SIGNATURE Hugh H. Owens (Degree or title)		23b. ADDRESS 1034 Quail Bldg	23c. DATE SIGNED 5-17-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial	24b. DATE 5-18-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Odeasa, Missouri
DATE REC'D BY LOCAL REG. 5-17-54	REGISTRAR'S SIGNATURE Steraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilly-Bylar, Kansas City, Mo.	

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

JUN 1 1966

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. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No.

P. O. Address... *M. C. N.*

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.