

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 25 1955

State File No. **11077**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **415**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>                         |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>---a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> |  |
| b. CITY OR TOWN <b>St. Joseph</b>                                      |  | c. CITY OR TOWN <b>St. Joseph</b>   |  |
| c. LENGTH OF STAY (In this place) <b>10 yrs.</b>                       |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>            |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Meth. Hospital</b> |  | e. STREET ADDRESS (If rural, give location) <b>721 Alabama St.</b>  |  |

|                                     |                          |                       |                         |   |
|-------------------------------------|--------------------------|-----------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>GEORGE</b> | b. (Middle) <b>W.</b> | c. (Last) <b>PARKER</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>April 16, 1955</b> |
|-------------------------------------|--------------------------|-----------------------|-------------------------|---|

|                    |                               |   |  |   |                             |                             |
|--------------------|-------------------------------|---|--|---|-----------------------------|-----------------------------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b> | 8. DATE OF BIRTH <b>March 28, 1877</b> | 9. AGE (In years last birthday) <b>78</b> | IF UNDER 1 YEAR Months Days | IF UNDER 14 HRS. Hours Min. |
|--------------------|-------------------------------|---|--|---|-----------------------------|-----------------------------|

|   |   |  |  |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
|---|---|--|--|

|                                       |  |   |
|---------------------------------------|--|---|
| 13a. FATHER'S NAME <b>John Parker</b> | 13b. MOTHER'S MAIDEN NAME <b>Elizabeth Guyer</b> | 14. NAME OF HUSBAND OR WIFE <b>Rosie Gerbrand Parker (de)</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>Goldie Pummell</b> | ADDRESS <b>721 Alabama St. St. Joseph, Mo.</b> |
|---|-------------------------------------|---|--|

|   |  |  |                                  |
|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
| *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease with Mitral Insufficiency</b> |  | <b>Ukn.</b>                      |
|   | ANTECEDENT CAUSES  |  |                                  |
|   | Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.            |  |                                  |
|   | DUE TO (c)   |  |                                  |
|   | II. OTHER SIGNIFICANT CONDITIONS <b>Diabetes Mellitus</b>  |  | <b>Ukn.</b>                      |
|   | Conditions contributing to the death but not related to the disease or condition causing death.                        |  |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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) (Min.) | 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 **2-9**, 19 **51**, to **4-16**, 19 **55** that I last saw the deceased alive on **4-16**, 19 **55**, and that death occurred at **7:15P** m., from the causes and on the date stated above.

|   |  |                                 |
|---|--|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>Chew W. Slattery MD</b> | 23b. ADDRESS <b>Tootle Building St. Joseph, Missouri</b> | 23c. DATE SIGNED <b>4-18-55</b> |
|---|--|---------------------------------|

|   |                            |   |  |
|---|----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>4-18-1955</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Kerlin Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>Halls, Missouri</b> |
|---|----------------------------|---|--|

|  |  |     |  |                                |
|--|--|-----|--|--------------------------------|
| DATE REC'D BY LOCAL REG. <b>April 21, 1955</b> | REGISTRAR'S SIGNATURE <b>Robert M. Allison</b> | 485 | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Phyllis Rupp</b> | ADDRESS <b>St. Joseph, Mo.</b> |
|--|--|-----|--|--------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

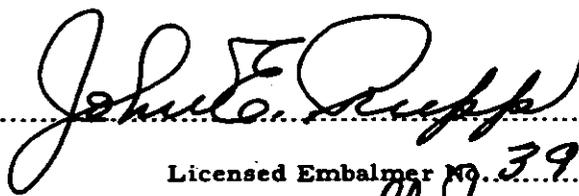
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by me, ~~or by~~ ....., Student Embalmer No. ....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... 

Licensed Embalmer No. 392

P. O. Address St. Joseph

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.