

FILED SEP 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32034

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>	
b. CITY OR TOWN <u>Rural, Washington</u>	c. LENGTH OF STAY (in this place) <u>13 yrs</u>	c. CITY OR TOWN <u>Flemington Mo. Gen Delivery</u>	d. Is 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 <u>State Hospital #3</u>		e. STREET ADDRESS (If rural, give location) <u>none given</u> 0430 0431	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Jessie</u>	b. (Middle) <u>Fay</u>	c. (Last) <u>Parker</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 14 1955</u>
-------------------------------------	--------------------------	------------------------	-------------------------	---

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 15 1915</u>	9. AGE (In years last birthday) <u>40</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-----------------	---------------------------	--	--------------------------------------	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	---	--	---

13a. FATHER'S NAME <u>Roy Parker</u>	13b. MOTHER'S MAIDEN NAME <u>Hazel Boyle</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
--------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Hazel Fisher</u> ADDRESS <u>Flemington</u>
--	-------------------------------------	---

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbidity 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. <u>Mental Deficiency</u>		40 years	

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	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 4 Nov 1942 to 15 Sept 1955, that I last saw the deceased alive on 15 Sept, 1955, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Frank J. Uryin MD</u>	23b. ADDRESS <u>State Hospital #3</u>	23c. DATE SIGNED <u>Sept 15 1955</u>
---	---------------------------------------	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>Sept 16 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lehman Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Wheatland, Mo</u>
---	-------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>9-17-55</u>	REGISTRAR'S SIGNATURE <u>Anna J. Ferris</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Gilbert Hathaway</u> ADDRESS <u>Wheatland, Mo</u>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

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

SFF 07 95

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 *Mrs. Gilbert H. Hathaway*

Licensed Embalmer No. *4267*

P. O. Address *Wheaton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.