

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34167

State File No. 4422

No. 300  
10-48

FILED OCT 24 1956

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>St. Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>KANSAS CITY</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>Research Hosp</u>				STREET ADDRESS (If rural, give location) <u>5620 Scarrill</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Pearl</u> b. (Middle) <u>Marie</u> c. (Last) <u>PARMAN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 9 1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 30 1894</u>		9. AGE (In years last birthday) <u>62</u>	If UNDER 1 Year Months <u></u> Days <u></u>	If UNDER 11 hrs. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Warsaw Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Samuel K Crawford</u>			13b. MOTHER'S MAIDEN NAME <u>Ella Colberd</u>		14. NAME OF HUSBAND OR WIFE <u>Arthur Parman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>499-07-5228</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Arthur Parman, K.C. Mo</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peritonitis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating underlying cause last. DUE TO (b) <u>Decayed Fistula</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> <u>545+</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Structure of Common Bile Duct.</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <u>9-16</u> , 19 <u>56</u> , to <u>10-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-8</u> , 19 <u>56</u> and that death occurred at <u>2:30</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Walter Cummins, M.D.</u> (Degree or title)				23b. ADDRESS <u>1617 Prof Bldg</u>		23c. DATE SIGNED <u>10-9-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/11/56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Raytown, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-11-56</u>		REGISTRAR'S SIGNATURE <u>Mona Minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clark Fegert, Raytown, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Walter Cummins, M.D.

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, *John R. Erdman*.....

Licensed Embalmer, No. *453*.....

P. O. Address *Punxsutawick*.....

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.