

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

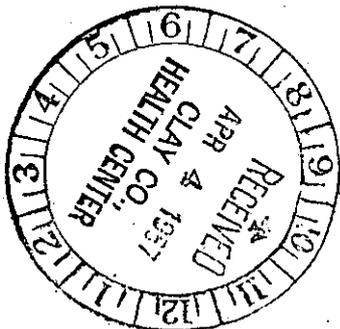
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State File No.

FILED APR 8 - 1957

BIRTH NO. _____		REG. DIST. NO. <u>91</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>25</u>		
1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>				
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>EXCELSIOR SPRINGS</u>		c. LENGTH OF STAY (in this place) <u>7 HRS</u>		c. CITY OR TOWN <u>LAWSON 609</u>		Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>EXCELSIOR SPRINGS HOSPITAL</u>				f. STREET ADDRESS (If rural, give location) <u>3 MI SW. LAWSON, Mo.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>DELLA</u>			b. (Middle) <u>LUCRETIA</u>		c. (Last) <u>PARADIS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAR. 20 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>8-8-1886</u>		9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>CHILLICOTHE, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>CASPER SNOOK</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH LAMP</u>		14. NAME OF HUSBAND OR WIFE <u>WM. PARADIS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>LURA DALZELL</u> ADDRESS <u>4630 FOREST ST. R.C. Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction</u>				DUPLICATE OF (b) <u>Coronary Thrombosis</u>				<u>36 HRS.</u>
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				DUPLICATE OF (c) <u>none</u>				<u>unk.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>none</u>				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>				20. AUTOPSY? <u>2</u> 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)		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>9-19</u> , 1957, to <u>9-20</u> , 1957, that I last saw the deceased alive on <u>9-20</u> , 1957, and that death occurred at <u>12:50 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>John Musgrave M.D.</u>				23b. ADDRESS <u>Excelsior Springs, Mo.</u>		23c. DATE SIGNED <u>3-20-57</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3-22-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LAWSON</u>		24d. LOCATION (City, town, or county) (State) <u>LAWSON, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3-26-57</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Prichard Funeral Home, Inc.</u> Address <u>Excelsior Springs, Missouri</u>				

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



JUN 3 1957

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 *Ralph Van Landingham*

Licensed Embalmer No. *4400*

P. O. Address *Springfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.