Health, & Welfare Public Service

S. 300 . 1-56

FILED APR 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12888
STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 71

1. PLACE OF DEATH
a. COUNTY Harrison
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bethany — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Noll Hospital — Length of stay in 1b 20 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Daviess
c. CITY OR TOWN Pattonsburg 310 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS -- (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First John Middle Zibe Last Parker

4. DATE OF DEATH Month March Day 30 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH August 16, 1878
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor
10b. KIND OF BUSINESS OR INDUSTRY General Practioneer
11. BIRTHPLACE (City and state or country) White Cloud, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Parker
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs. Gladine Parker, Pattonsburg, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Prostate with
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized Metastasis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 2 yrs?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 177X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-4-57 to 3-30-57 and last saw her/him alive on 3-30-57
Death occurred at 8:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. S. Gray (Degree or title) MD
22b. ADDRESS Bethany Mo
22c. DATE SIGNED 4/1/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE April 2, 1957
23c. NAME OF CEMETERY OR CREMATORY Altamont Cemetery
23d. LOCATION (City, town, or county) Altamont, Missouri (State)

24. FUNERAL DIRECTOR Louis Luest ADDRESS Pattonsburg, Missouri
25. DATE RECD. BY LOCAL REG. April 8-1957
26. REGISTRAR'S SIGNATURE Zola Burris

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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MAR 12 1958

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 409

P. O. Address Pattonsburg

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