

FILED OCT 9 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32087

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4396300 D  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		Length of stay in 1b <b>7 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>4817 McGee Street</b> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAKE</b> Middle <b>L.</b> Last <b>PARSONS</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>19</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1903</b>
9. AGE (In years last birthday) <b>54</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wholesale Meat Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Williams Meat Co.</b>	11. BIRTHPLACE (City and state or country) <b>Montgomery County, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>William Parsons</b>	
13b. MOTHER'S MAIDEN NAME <b>Emma Parrish</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Flossie B. Parsons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>310-07-3132</b>	17. INFORMANT Address <b>Mrs. Flossie B. Parsons-4817 McGee St. K.C. Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor. Pulmonale = Heart failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Endogenous Bronchial Asthma</b> DUE TO (c) <b>Bronchiectasis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2+ years</b> <b>5+ years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	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 <u>June 1957</u> to <u>9/19/57</u> and last saw him alive on <u>9/18/57</u> Death occurred at <u>7:30 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Morgan U. Stoeckwell M.D.</b>		22b. ADDRESS <b>1630 Prot. Bldg. J.C. Mo.</b>	22c. DATE SIGNED <b>9/20/57</b>
23a. BURIAL REMOVAL, (Specify) <b>Burial</b>	23b. DATE <b>9/23/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>QUIRK &amp; TOBIN-20 W. Linwood, K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-21-57</b>	26. REGISTRAR'S SIGNATURE <b>neva Marshall</b>

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Morgan U. Stoeckwell

All diseases in Part I must be causally related.



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 *E. E. Gibson* .....

Licensed Embalmer No. *4137* .....

P. O. Address *KC 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.