

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032057
STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 71

DECEASED OCT 1 1958

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>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u>		Length of stay in 1b <u>2 Days</u>	d. STREET ADDRESS (If outside, give location) <u>1612 Tracy</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HERSCHEL</u> Middle <u>F.</u> Last <u>PARKS</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>3</u> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>November 7, 1891</u>
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cafe</u>	11. BIRTHPLACE (City and state or country) <u>Clinton, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry Parks</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Divorced</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>490 05 8347</u>	17. INFORMANT Address <u>VA Hospital records</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis, pulmonary, chronic, far advanced, active.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>13 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			<u>002 X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Emphysema, pulmonary, bilateral, severe</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>- - -</u>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>- - -</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>- - -</u>	
21. I attended the deceased from <u>Sept. 17, 1958</u> to <u>Sept. 19, 1958</u> Death occurred at <u>9:45 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>C.V. KERN, M.D. Chief, Tuberculosis Service</u>		22b. ADDRESS <u>VAH, Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>9-22-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>9-21-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNKNOWN</u>	23d. LOCATION (City, town, or county) (State) <u>CLINTON, MO.</u>
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>9/24/58</u>	26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.



Name of Deceased _____
 Date of Death _____
 Place of Death _____
 Cause of Death _____
 Burial Place _____

Date of Embalming _____
 Place of Embalming _____
 Name of Embalmer _____
 License No. _____
 Signature of Embalmer _____
 Date of Signature _____

FEB 7 1962
 MS

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 Lindeed Jarman

Licensed Embalmer No. 4589
 P. O. Address Excelsior Springs, 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.