

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035374
STATE FILE NUMBER

FILED OCT 23 1958 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 221

1. PLACE OF DEATH a. COUNTY <u>Audain Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Mo.</u> COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Middletown</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Allen Nursing Home - 3 weeks</u> Length of stay in lb		0700 STREET ADDRESS (If outside, give location) <u># 7 mi. E.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ALVIN</u> Middle <u>PARKEY</u> Last <u>PARKEY</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1958</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 28, 1887</u>	9. AGE (In years last birthday) <u>71 yrs</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Montgomery Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Parkey</u>	13b. MOTHER'S MAIDEN NAME <u>Mary E. Dillon</u>	14. NAME OF HUSBAND OR WIFE _____
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15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Amanda Healyer, Middletown Mo</u>
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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>Cerebral Thrombosis recurrent</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>5 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</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.)
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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"/> AT 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
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21. I attended the deceased from <u>9-21-58</u> to <u>10-11-58</u> and last saw ^{him} alive on <u>10-4-58</u> Death occurred at <u>2:15</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>M. S. Kellenbach M.D.</u>	22b. ADDRESS <u>Mexico, Mo</u>	22c. DATE SIGNED <u>10-18-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 13, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Middletown Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Ad. Ritzlett Middletown Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 13-1958</u>	26. REGISTRAR'S SIGNATURE <u>Blenche Healy</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
G.P. J. B. L. E. N. F. P. C. H.

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OCT 27 1958

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 W. Butler*

Licensed Embalmer No. *4447*
P. O. Address *Bowling Green*

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.