

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002063  
STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

300  
-57

Registration District No. 195 Primary Registration District No. \_\_\_\_\_ Registrar's No. 6-59

1. PLACE OF DEATH a. COUNTY <b>McDonald</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>McDonald</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Elk River</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Noel</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>At Home</b>		Length of stay in lb <b>lifelong</b>	d. STREET ADDRESS (If outside, give location) <b>Rt. 2</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Jess</b> Middle <b>A.</b> Last <b>Parish</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>5</b> Year <b>1959</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14 1873</b>	9. AGE (In years last birthday) <b>85</b>	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) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	11. BIRTHPLACE (City and state or country) <b>Noel, Mo. Rt. 2</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>John Parish</b>	13b. MOTHER'S MAIDEN NAME <b>Melinda Starns</b>	14. NAME OF HUSBAND OR WIFE <b>deceased</b>
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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>none</b>	17. INFORMANT <b>Everett Parish</b>	Address <b>Noel, Mo. Rt. 2</b>
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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>myocardial decompensation</u> DUE TO (b) <u>myocardial infarction</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4281</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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 Death occurred at <u>1:30</u> <u>1950</u> to <u>Jan 5-59</u> and last saw <sup>her</sup> <sub>him</sub> <u>live on Jan 5, 59</u> 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>J.P. Fountain M.D.</u>	22b. ADDRESS <u>Noel, Mo.</u>	22c. DATE SIGNED <u>1-13-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-7-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shelt-Noel cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Noel, Mo. Rt2 Mo.</b>
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24. FUNERAL DIRECTOR <b>Humphrey &amp; Son</b>	ADDRESS <b>Noel, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Jan 29 1959</b>	26. REGISTRAR'S SIGNATURE <u>Mary G. Bradley</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. M. Humphrey Jr.* .....

Licensed Embalmer No. *4708* .....  
P. O. Address *Nash 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.