

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020485

FILED JUL 3 1959 042

1000

674

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 674

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 45 years	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR NURSING HOME INSTITUTION Sunny Slope Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 302 1/2 Illinois Ave.
3325 So. 11th St.		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Orba	Middle F.	Last Paris	Month June 27, 1959	Day	Year

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 86	9. AGE (last birthday) 72	IF UNDER 1 YEAR	IF UNDER 24 HR
					Months	Days
					Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weight Master (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Larabee Milling Co.	11. BIRTHPLACE (City and state or country) Craig, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Douglas Paris		13b. MOTHER'S MAIDEN NAME Eva Edge		14. NAME OF HUSBAND OR WIFE Gertrude Paris
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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) No	16. SOCIAL SECURITY NO. 497-09-0473A	17. INFORMANT Mrs. Eva Foster 302 1/2 Illinois Ave.	
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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:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral Vascular Accident			2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Arteriosclerosis	1 month	
	Arteriosclerosis	unknown	
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days.
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 a.m. p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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 3/2/54 to 6/27/59 and last saw him alive on 6/27/59
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 (Degree or title) Sharon El Woggoner M.D.	22b. ADDRESS 301 Illinois Ave St. Joseph, Missouri	22c. DATE SIGNED 6/29/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 30, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Mo.
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24. FUNERAL DIRECTOR Clark Funeral Home St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. June 30, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Standall
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF S.E. Woggoner, M.D. 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Earl A. Clark

Licensed Embalmer No. 4231

P. O. Address St. Joseph

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.