

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1959

59-028421

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 61

DEED

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>		c. CITY OR TOWN <u>Norborne</u>	
Length of stay in 1b <u>1 wk.</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>Bales Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>210 W. 2<sup>nd</sup></u>	
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) First Middle Last <u>CLIFFORD LEE PARKS</u>			4. DATE OF DEATH Month Day Year <u>Aug. 15-1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16, 1918</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas station attendant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>oil.</u>	11. BIRTHPLACE (City and state or country) <u>Ray Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>William Parks</u>	13b. MOTHER'S MAIDEN NAME <u>Nellie Gardner</u>	14. NAME OF HUSBAND OR WIFE <u>Nadine Elliott Parks</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>488-32-8035</u>	17. INFORMANT <u>Mrs. Nadine Parks, Norborne Mo</u>	Address
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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) <u>Probable gastric ulcer, perforating</u>		<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Diabetic coma 423 mgm blood sugar</u>	<u>7 days</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)	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
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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 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 8 Aug 59 to 15 Aug 59 and last saw her alive on 15 Aug  
Death occurred at 545 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. W. Allen M.D.</u>	22b. ADDRESS <u>111 Folsom Carrollton</u>	22c. DATE SIGNED <u>17 Aug 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 18, 1959</u>	<u>Fairhaven Cem</u>	<u>Norborne Mo.</u>

24. FUNERAL DIRECTOR <u>Gibson Funeral Home, Norborne, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8/17/59</u>	26. REGISTRAR'S SIGNATURE <u>Tom Verber Carter</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS JUN 1 1960

**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

*Ben W. Gibson*

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.