

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-032181

STATE FILE NUMBER

AMENDED

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 18

**FILED OCT 10 1961**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cedar</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>El Dorado Springs</u> Length of stay in lb <u>6 da.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cedar Co. Memorial Hos.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u> c. CITY OR TOWN <u>El Dorado Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>121 W. Fields Blvd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ada</u> Middle <u>Mae</u> Last <u>Parker</u>			<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>5</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2-12-1898</u>	<b>9. AGE</b> (last birthday) <u>63</u>	<b>IF UNDER 1 YEAR</b> Months <u>        </u> Days <u>        </u>	<b>IF UNDER 24 HR</b> Hours <u>        </u> Min. <u>        </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hume, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		
<b>13a. FATHER'S NAME</b> <u>William Williams</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Rose White</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Nay Parker</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>17. INFORMANT</b> Address <u>Nay Parker, El Dorado Springs, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemolytic crisis</u> DUE TO (b) <u>due to acute idiopathic hemolytic anemia</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH	
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <u>December 1960</u> to <u>Oct. 5, 1961</u> and last saw her <u>alive</u> on <u>Oct. 5, 1961</u> Death occurred at <u>11:05 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <u>Robert L. Magee M.D.</u>			<b>22b. ADDRESS</b> <u>808 S. Main, El Dorado Springs, Missouri</u>		<b>22c. DATE SIGNED</b> <u>10/6/61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>10-8-1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Memorial Gardens</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Johnson County Kansas</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Gwinn-Carothers, El Dorado Springs Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-6-61</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Dave Bassett</u>		

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 SHOULD READ  
 ITEM NO.

**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

*Max W. Dickering*

Licensed Embalmer No. 4696

P. O. Address El Dorado

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.