

# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-63-015529

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 80

**FILED APR 25 1963**

1. PLACE OF DEATH a. COUNTY <u>Dunklin Co.</u>		2. USUAL RESIDENCE (Where deceased lived or institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Hermondale</u>		Length of stay in 1b <u>3 1/2 yrs</u>	c. CITY OR TOWN <u>St. Hermondale</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>Dunklin Co. Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside give location) <u>R. 3, Steele, Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>Parr</u> Last <u>Parr</u>			4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>63</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</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>1/29/1896</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Tenn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>Muriel Parr</u>	13b. MOTHER'S MAIDEN NAME <u>Mattie Basic</u>	14. NAME OF HUSBAND OR WIFE <u>Adella Parr</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>Adella Parr, R. 3, Steele, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepaloma Liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48</u>
Conditions, if any, which gave rise to above cause. (a), stating the underlying cause last. DUE TO (b) _____ 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 checked="" 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 checked="" 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 2-28-63 to 3-20-63 and last saw him alive on 3-20-63  
Death occurred at 10:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul Mitenbeyer M.D.</u>	22b. ADDRESS <u>Dennell Mo.</u>	22c. DATE SIGNED <u>4-22-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/24/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nickman Park</u>	23d. LOCATION (City, town, or county) (State) <u>Nickman, Ark</u>
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24. FUNERAL DIRECTOR <u>Cecil W. Harne, Blytheville, Ark</u>	25. DATE RECD. BY LOCAL REG. <u>4-24-63</u>	26. REGISTRAR'S SIGNATURE <u>Paul Husband</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300  
Rev. 4/59  
0350  
2350  
3  
4 2  
5 1  
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7 1  
8 1  
9/55.0  
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12 2-0  
13 5-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

APR 2 1968

**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 Cecil Thomas Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.