

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027349

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 955

DO NOT WRITE ON THIS STUB

AMENDED

<p>FILED AUG 12 1963</p> <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Buchanan</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Length of stay in lb <u>75 Years</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1611 Faraon St.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u></p> <p>c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>1611 Faraon St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>									
<p>3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle Last <u>PARNHAM</u></p>		<p>4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1963</u></p>									
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>White</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>9-7-1870</u></p>	<p>9. AGE (last birthday) <u>92</u></p>	<p>IF UNDER 1 YEAR Months Days Hours Min.</p>	<p>IF UNDER 24 HR Hours Min.</p>					
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>Jacksonville, Ill.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>					
<p>13a. FATHER'S NAME <u>William Lloyd</u></p>			<p>13b. MOTHER'S MAIDEN NAME <u>Veronica</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>William</u></p>						
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u></p>			<p>16. SOCIAL SECURITY NO. _____</p>		<p>17. INFORMANT Address <u>Mrs Lurley Burley 1611 Faraon City</u></p>						
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Atherosclerosis</u></p> <p style="text-align: center;">DUE TO (b) _____</p> <p style="text-align: center;">DUE TO (c) _____</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>						<p>INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u></p>					
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>					<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>						
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>							
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		<p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>					
<p>21. I attended the deceased from <u>1950</u> to <u>8-7-63</u> and last saw her alive on <u>8 7 63</u></p> <p>Death occurred at <u>7:45 a</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>						<p>22a. SIGNATURE (Degree or title) <u>C. DuMont Medical Certification</u></p>		<p>22b. ADDRESS _____</p>		<p>22c. DATE SIGNED <u>8 7 63</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>8-9-1963</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u></p>					
<p>24. FUNERAL DIRECTOR ADDRESS <u>H. O. Sidenfaden & Son St. Joseph, Mo.</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>Aug 9, 1963</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u></p>						

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 8-9-63

2117
2118
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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.

0-00

Student _____
Signature of Student Embalmer

Signed Robert H. Gable

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.