

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042630

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 195

STATE FILE NUMBER

FILED OCT 22 1963

VS 300 Rev. 4/59	DATE AMENDED	
1075	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	
2 1075	INSTEAD OF	
3	DOCUMENT	
4 0	MEDICAL CERTIFICATION	
5 B	BY AFFIDAVIT OF	
6		
7 0		
8 2		
9 200		
10		
11		
12 260		
13 10		
ITEM NO.	SHOULD READ	

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Nevada</u>		Length of stay in lb <u>2 years</u>	c. CITY OR TOWN <u>Nevada</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>#812 N. Washington St Tates Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert Parsons</u>			4. DATE OF DEATH Month Day Year <u>Oct 8, 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/28/1874</u>
9. AGE (last birthday) <u>89</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>Common Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Barton Co. Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>US</u>		13. NAME OF HUSBAND OR WIFE <u>None</u>	
13a. FATHER'S NAME <u>Martin Parsons</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Hosmer</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		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>[Redacted]</u>		17. INFORMANT Address <u>Mrs. C. H. McTee Sheldon Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with auricular fibrillation, decompensated, Class IV</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, generalized, severe</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			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>
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.)	
20c. TIME OF INJURY Hour a.m. p.m.	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
21. I attended the deceased from <u>Nov 11, 1960</u> to <u>Oct 8, 1963</u> and last saw her alive on <u>Oct 4, 1963</u> Death occurred at <u>4:35 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James J. Parson MD</u>		22b. ADDRESS <u>Moore Building, Nevada, Mo.</u>	22c. DATE SIGNED <u>10-14-63</u>
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 10 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sheldon</u>	23d. LOCATION (City, town, or county) (State) <u>Sheldon Mo</u>
24. FUNERAL DIRECTOR <u>Beeny Funeral Home Sheldon Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-17-1963</u>	26. REGISTRAR'S SIGNATURE <u>Armal J. Jurey</u>	

USE BLACK INK OR TYPEWRITER RIBBON

08154-1001

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 L. H. Beery

Licensed Embalmer No. 7203

P. O. Address Heldon 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.