

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042876
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

38

Primary Registration District No.

3006

Registrar's No.

827

FILED DEC 3 1963

VS 300
Rev. 4/59

DATE AMENDED

0109
20648

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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

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MARIAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		Length of stay in 1b <u>2 Mo</u>	c. CITY OR TOWN <u>HANNIBAL</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>BOONE COUNTY HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2411 BROADWAY</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BIRDIE</u> Middle <u>O</u> Last <u>PARKS</u>			4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>63</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-1874</u>
9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Howard Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Benjamin Hall</u>	
13b. MOTHER'S MAIDEN NAME <u>ELIZA BEVERLY</u>		14. NAME OF HUSBAND OR WIFE <u>William Wirt Parks</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>—</u>	
17. INFORMANT <u>Mrs. John Ruff, Columbia, Mo</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS (REPORTED)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CEREBRAL SCLEROSIS</u>			<u>YEARS</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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. Month, Day, Year	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>October 29 63 to Nov 30, 1963</u> and last saw her alive on <u>Nov 29, 1963</u> Death occurred at <u>345</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Charles A. Leach M.D.</u> (Degree or title)		22b. ADDRESS <u>Columbia, Mo</u>	22c. DATE SIGNED <u>Nov 30, 1963</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-1-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>GLASGOW, MISSOURI</u>
24. FUNERAL DIRECTOR <u>PARKER FUNERAL SERVICE, COLUMBIA, MO</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Nov. 30, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R & Palmer</u>

ATRS:0-002

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,

for by _____, Student Embalmer No. _____

working under my personal supervision.

(Student) _____
Signature of Student Embalmer

Signed Donald L Roberts

Licensed Embalmer No. 4922

P. O. Address Columbia 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.