

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044187

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6295

FILED DEC - 2 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>30yrs</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>Wheatley Provident Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>3740 Brooklyn</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>Dorsey</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>63</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</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>10-21-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>79</u>
11a. BIRTHPLACE (City and state or country) <u>Arrow Rock, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Dan Parker</u>		13b. MOTHER'S MAIDEN NAME <u>Charlotte Smith</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		17. INFORMANT <u>Sallie Strawther 3640 Euclid</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If <u>no</u> give war or dates of service)		16. SOCIAL SECURITY NO.	
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>Acute Congestive heart failure</u> arteriosclerotic heart disease DUE TO (b) <u>pulmonary fibrosis</u> DUE TO (c) <u>pulmonary fibrosis</u> 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			
19. WAS AUTOPSY PERFORMED? YES <input 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.)	
20c. TIME OF INJURY Hour <u>4:15</u> a.m. <u>11-13-63</u> Month, Day, Year		20f. CITY, TOWN, OR LOCATION <u>Arrow Rock, Mo.</u>	
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.)	
21. I attended the deceased from <u>11-13-63</u> to <u>11-17-63</u> and last saw <u>her</u> alive on <u>11-17-63</u> Death occurred at <u>4:15</u> p. <u>o.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>V. L. Dixon</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Kansas City, Mo. 64127</u>	
22c. DATE SIGNED <u>11/18/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-24-63</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Arrow Rock, Mo.</u>	
24. FUNERAL DIRECTOR <u>Watkins Bros. Funeral Home 18th Benton</u>		25. DATE RECD. BY LOCAL REG. <u>11-19-63</u>	
26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>			

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATE OF MISSOURI  
DEPARTMENT OF HEALTH

2000-01

**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 Bruce A. Watkins

Licensed Embalmer No. 4500

P. O. Address 1000 Benton

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.