S. No. 300
v. 10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 1 - 1953

State File No. 41937

BIRTH NO. _____ REG. DIST. NO. 371 PRIMARY REG. DIST. NO. 6259 Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY: WEBSTER
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Seymour RFD 3
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): E. Benton Jones

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: WEBSTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1120 0
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) LEMUEL b. (Middle) G c. (Last) PARNELL

4. DATE OF DEATH: (Month) 11 (Day) 10 (Year) 53

5. SEX: M 0

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2

8. DATE OF BIRTH: 4-2-1867

9. AGE (In years last birthday): 86 | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING JUDGE

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): CHRISTIAN C.O 0

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: JOSHUAH.

13b. MOTHER'S MAIDEN NAME: SICILY TUCKER

14. NAME OF HUSBAND OR WIFE: LUCINDA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No | (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: AVA E. PURSLEY SEYMOUR MO

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Liver

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: No Autopsy 1561

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10/28, 1953, *to* 11/10/, 1953, *that I last saw the deceased alive on* 11/9, 1953 *and that death occurred at* 9:50 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. R. Schultz DR

23b. ADDRESS: Ford Ky. Mo.

23c. DATE SIGNED: 11/14/53

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: 11-13-53

24c. NAME OF CEMETERY OR CREMATORY: SEYMOUR

24d. LOCATION (City, town, or county) (State): WEBSTER C.O Mo.

DATE REC'D BY LOCAL REG.: 11-26-53

REGISTRAR'S SIGNATURE: Opal M. Goodwin

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert Bergman Seymour MO

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 .....
Student Embalmer

Signed Max L Miller

Licensed Embalmer No. 4720

P. O. Address Fordland 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 this body is not embalmed, fact should be so stated above.