

FILED JUL 6 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19885

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>234</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Sedalia</u> )		c. LENGTH OF STAY (In this place) <u>27 yrs</u>		c. CITY OR TOWN <u>Sedalia</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1501 S. Moniteau</u>				e. STREET ADDRESS (If rural, give location) <u>1501 S. Moniteau</u> <span style="float: right;">080%</span>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>OLGA</u> b. (Middle) <u>L.</u> c. (Last) <u>PARSONS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 29, 1954</u>				
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 23, 1892</u>		9. AGE (In years last birthday) <u>62</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 10 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Alma, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Frank Witte</u>		13b. MOTHER'S MAIDEN NAME <u>Alvina Buck</u>		14. NAME OF HUSBAND OR WIFE <u>Dr. C. B. Parsons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>N</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Dr. C. B. Parsons, Sedalia, Mo</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Massive basal cerebral hemorrhage</u>  ANTECEDENT CAUSES DUE TO (b) <u>Hypertension</u>  DUE TO (c) <u>Arterio-Sclerosis</u>  II. OTHER SIGNIFICANT CONDITIONS <u>Over-weight &amp; neuro-syphillis</u> <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>5 yrs.</u> <u>5 yrs.</u> <u>5 yrs.</u>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>331XB</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from _____, 19 <u>49</u> to <u>6-28-</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>6-28-</u> , 19 <u>54</u> , and that death occurred at <u>4:00Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Harold B. Conroy</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Sedalia, Mo</u>		23c. DATE SIGNED <u>6-30-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1 July 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>7-2-54</u>	REGISTRAR'S SIGNATURE <u>Lavinia Coons Deputy</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Beckhart</u>		ADDRESS <u>Sedalia, Mo</u>	

(Signed Embalmer's Statement on Reverse Side)

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

GILLESPIE TONING POWER

JUL 2 1952

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..... *W. Beckhart*

Licensed Embalmer No. *3470*

P. O. Address *Sidala*

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.