

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34818

FILED NOV 4 1957

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 393

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Licking</u> 1070 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. of Mo. Med Center 22 di. Hous.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Success Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>La Vera</u> Middle <u>MAE</u> Last <u>Parker</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1901</u>
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Hogden Nebraska</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Barnatt</u>	13b. MOTHER'S MAIDEN NAME <u>Della Crabtree</u>
14. NAME OF HUSBAND OR WIFE <u>Louis Parker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>V</u>
17. INFORMANT <u>Hospital Chart U. of Mo. Med. Center</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>Possible bronchopneumonia</u> DUE TO (b) <u>Dermatomyomycosis</u> DUE TO (c) <u>7100</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Asytemia; diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 months?</u>
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		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>8:10 p.</u> Month, Day, Year <u>10/25/57</u> a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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>10/3/57</u> to <u>10/25/57</u> and last saw her alive on <u>10/25/57</u> Death occurred at <u>8:10 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Frank H. Mohr, M.D.</u>		22b. ADDRESS <u>U. of Mo. Med Center, Columbia, Mo</u>	22c. DATE SIGNED <u>10/25/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/28/1957</u>	<u>Licking Cemetery</u>	<u>Licking, Mo.</u>
24. FUNERAL DIRECTOR <u>Lynn J. Smith</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 26 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>

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 *Lynard H. Sprinkle*

Licensed Embalmer No. *4013*

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.