

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43407  
STATE FILE NUMBER  
Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 294

FILED DEC 30 1957

S. 300  
v. 1-57

|   |                               |   |  |  |   |
|---|-------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Audrain</u>   |                               |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Mexico</u>  |                               | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Mexico</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Audrain Hospital</u>  |                               | Length of stay in lb<br><u>33</u> days  | d. STREET ADDRESS (If outside, give location)<br><u>618 S. Washington</u>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>John</u> Middle <u>R.</u> Last <u>Paradies</u>   |                               |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>12</u> Year <u>1957</u>   |  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 7, 1880</u>   |  | 9. AGE (In years last birthday) <u>77</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Real Estate Broker</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Real Estate</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Calrey, Illinois</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |
| 13a. FATHER'S NAME<br><u>Peter Paradies</u>   |                               | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Fredrick</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Cora Carmine Paradies</u>                                  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give dates of service)<br><u>no</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>488-38-0974</u>   |  | 17. INFORMANT<br><u>Mrs. Cora Paradise</u> Address <u>618 S. Washington Mexico, Missouri</u> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u>  |                               |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12-15-57</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____<br>DUE TO (c) _____   |                               |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>203X</u>  |                               |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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>12-15-57</u> to <u>Dec 13 1957</u> and last saw <u>her</u> alive on <u>12-12-57</u><br>Death occurred at <u>11:10 am</u> on the date stated above; and to the best of my knowledge, from the causes stated. |                               |   |  |  |   |
| 22a. SIGNATURE <u>O. L. Lawrence (M.D.)</u> (Degree or title)   |                               |   | 22b. ADDRESS <u>Mexico, Mo.</u>  |  | 22c. DATE SIGNED <u>12-13-57</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                               | 23b. DATE<br><u>12-16-1957</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Brendans Cemetery</u>   |  | 23d. LOCATION (City, town, or county) (State)<br><u>Mexico, Missouri</u>                          |
| 24. FUNERAL DIRECTOR<br><u>Arnold Funeral Home</u> ADDRESS <u>Mexico, Mo.</u>   |                               |   | 25. DATE RECD. BY LOCAL REG.<br><u>Dec 13-1957</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Blanche Reely</u>  |   |

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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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  .....

Licensed Embalmer No. 2492  
P. O. Address Medico

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.