. Health,
& Welfare
. Public
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-022175
STATE FILE NUMBER

FILED JUL 8 1958 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 283

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Independence — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Indep. Sant. — Length of stay in lb 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Independence — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 7005 11207 E 25th St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First KENNETH Middle WAYNE Last PARKS

4. DATE OF DEATH Month July Day 2 Year 1958

5. SEX MALE
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Mar. 2. 1950
9. AGE (In years last birthday) 8 — 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) Child
10b. KIND OF BUSINESS OR INDUSTRY Child
11. BIRTHPLACE (City and state or country) Indep. Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Wm. Dale Parks
13b. MOTHER'S MAIDEN NAME Doris Alley
14. NAME OF HUSBAND OR WIFE —

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. None
17. INFORMANT Wm. Dale Parks — Address 11207 E 25th St. Indep. Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH 24 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral palsy (congenital) — congenital
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 351X
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ] 1

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 6-30-58, to 7-2-58 and last saw her/him alive on 7-2-58
Death occurred at 1:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James T. VanBiber M.D.
22b. ADDRESS 317 W Kansas Indep. Mo.
22c. DATE SIGNED 7-3-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7-5-58
23c. NAME OF CEMETERY OR CREMATORY MT. Washington
23d. LOCATION (City, town, or county) Independence (State) Mo.

24. FUNERAL DIRECTOR Geo. C. Carson & Sons — ADDRESS Indep. Mo.
25. DATE RECD. BY LOCAL REG. 7-4-58
26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Independence, 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.