

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000507  
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY <u>Cape</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Charleston, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S. E. Hosptial</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>304 E. Commercial</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>Wm. Isaiah Park</u>			4. DATE OF DEATH Month Day Year <u>Jan. 21, 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	11. BIRTHPLACE (City and state or country) <u>Sullivan, Mo.</u>
13a. FATHER'S NAME <u>Wm. Joseph Park</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah ?</u>	14. NAME OF HUSBAND OR WIFE <u>Anna L. Day Park</u>
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, OR COAST GUARD? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Fred Kinder Charleston, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pemphigus Vulgaris</u> DUE TO (b) <u>Chronic C.V. disease (old)</u> DUE TO (c) <u>Left Cerebral aneurysm.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>prolonged therapy.</u>			19. INTERVAL BETWEEN ONSET AND DEATH <u>7c/1</u> 20. WAS AUTOPSY PERFORMED? 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 Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>December 27th '58</u> to <u>January 21, 1959</u> and last saw <u>her</u> alive on <u>January 21, 1959</u> Death occurred at <u>12:12 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William M. Estes M.D.</u>		22b. ADDRESS <u>Cape Girardeau, Mo. 714 Broadway</u>	22c. DATE SIGNED <u>1-28-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>1/23/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Slaybough</u>	23d. LOCATION (City, town, or county) (State) <u>Lutesville, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Mc Mickle Charleston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 29, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Homer Cooper</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 3

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 *[Handwritten Signature]*

Licensed Embalmer No. *4490*  
P. O. Address *Charleston*

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.