

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012825

STATE FILE NUMBER

FILED MAY 5 1959

Registration District No.

107

Primary Registration District No.

3019

Registrar's No.

77

1. PLACE OF DEATH a. COUNTY Dunklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Dunklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kennett Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kennett 0352
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1315 Ballard		Length of stay in 1b	d. STREET ADDRESS 1315 Ballard St
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Dennis Wayne Parker			4. DATE OF DEATH Month Day Year Apr. 30- 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3rd-1956	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months Days 7 27	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX	10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (City and state or country) Kennett Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Thomas J. Parker	13b. MOTHER'S MAIDEN NAME Juanita Hooker	14. NAME OF HUSBAND OR WIFE XX
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. XX	17. INFORMANT Thomas J. Parker	Address Kennett Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retino blastoma		INTERVAL BETWEEN ONSET AND DEATH 7 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 19.2X		19. 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.)
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20c. TIME OF INJURY Hour a.m. p.m. 	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 Kennett	COUNTY 	STATE
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21. I attended the deceased from Oct 1958 to April 30, 1959 and last saw him alive on April 30, 1959 Death occurred at 4:00 AM m of the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Chester R. Peck M.D.	22b. ADDRESS Kennett Mo.	22c. DATE SIGNED 5-1-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-2-59	23c. NAME OF CEMETERY OR CREMATORY Oak Ridge Cemetery	23d. LOCATION (City, town, or county) (State) Kennett Mo.
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24. FUNERAL DIRECTOR Lentz Service	ADDRESS Kennett Mo.	25. DATE RECD. BY LOCAL REG. 5-2-1959	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Edgar Lee Ford*

Licensed Embalmer No. *4433*
P. O. Address *Kennett*

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.