

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016474

STATE FILE NUMBER

FILED APR 30 1959 Registration District No. 347 Primary Registration District No. 4509 Registrar's No.

300
1-57

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

3. NAME OF DECEASED (Type or print) First Middle Last Dwight Scott Parsons			4. DATE OF DEATH Month Day Year Jan 19 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 Nov 13 1915	9. AGE (In years last birthday) 43	10. FUNDING YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locker Plant Operator		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Hurley, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME M.T. Parsons	13b. MOTHER'S MAIDEN NAME Lena Scott	14. NAME OF HUSBAND OR WIFE Allene Parsons
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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.	17. INFORMANT Address Allene Parsons, Crane, Missouri
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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) Primary carcimoma of urachus with metastasis to abdominal viscera, lungs, spine. 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) 1817		INTERVAL BETWEEN ONSET AND DEATH 16 mos.
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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 Month, Day, Year 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
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21. I attended the deceased from Nov - 1958, to Jan 19 - 1959 and last saw him alive on Jan - 18 - 1959 Death occurred at 4:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>A. P. Reynolds</i> M.D.	(Degree or title)	22b. ADDRESS Crane, Mo	22c. DATE SIGNED 1-21-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/21/59	23c. NAME OF CEMETERY OR CREMATORY I 20.0.F.	23d. LOCATION (City, town, or county) (State) Marionville, Missouri
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24. FUNERAL DIRECTOR Manlove Funeral Home, Crane, Mo	ADDRESS	25. DATE RECD. BY LOCAL REG. 4-30-59	26. REGISTRAR'S SIGNATURE <i>Thomas C. Hurdow</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *George H. Mander*

Licensed Embalmer No. *3877*

P. O. Address *Crane*

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.