

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025344

DIVISION VS JUL 27 1959

Registration District No. 249 Primary Registration District No. 1002 Registrar's No. 3350 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in lb <u>56 yrs</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>St. Marys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3326 Askew</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ludwell</u> Middle <u>E.</u> Last <u>Parker</u>			4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1877</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Delivery Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Union Pacific</u>		11. BIRTHPLACE (City and state or country) <u>Arkemoy Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>BENJAMIN Parker</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda J. Rector</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie B Parker</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>K712-01-7921</u>	17. INFORMANT <u>Bessie B Parker</u>	Address <u>3326 Askew</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>6-10-59 to 7-7-59</u>	COUNTY <u>7-7-59</u>	STATE <u>7-9-59</u>
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21. I attended the deceased from 6-10-59 to 7-7-59 and last saw ^{her}him alive on 7-9-59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Madam Owen M. D.</u>	(Deceased's title)	22b. ADDRESS <u>906 Grand</u>	22c. DATE SIGNED <u>7-8-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>
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24. FUNERAL DIRECTOR <u>Muehleback</u>	ADDRESS <u>6800 Troost</u>	25. DATE RECD. BY LOCAL REG. <u>7-8-59</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Madam Owen M. D.

Cr Richard Kline
4312 ZC Nichols PK.
Je 1-5757

In Balance

Rialto

Gr 1-0174

after 1:00

[Faint handwritten signature]

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed J. T. Crowell

Licensed Embalmer No. 490

P. O. Address H. C. 7

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to conform 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.