

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 21 1959

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STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 164

ENDED

1. PLACE OF DEATH a. COUNTY <b>Howell</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howell</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>West Plains</b>		Length of stay in 1b <b>41 yrs</b>		c. CITY OR TOWN <b>West Plains</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1029 Nichols Drive</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>Fred</b> Last <b>Park</b>				4. DATE OF DEATH <b>December 17, 1959</b> Month <b>December</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-12-81</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veteranarian</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Iola, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>George W. Park</b>			13b. MOTHER'S MAIDEN NAME <b>Sadie Mitchell</b>		14. NAME OF HUSBAND OR WIFE <b>Marguerite Park</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mitchell R. Park, Decatur, Ga.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b>
DUE TO (b) <b>Cerebral arteriosclerosis</b>							
DUE TO (c) <b>Hypertension, Essential</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Previous Cerebral Hemorrhage</b>							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
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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year					
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		COUNTY	STATE
21. I attended the deceased from <b>12-3-1958</b> to <b>12-11-59</b> and last saw him live on <b>12-11-59</b> Death occurred at <b>12-11-59 6:25am</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased's title) <b>Jack Wiles, M.D.</b>				22b. ADDRESS <b>West Plains, Mo</b>		22c. DATE SIGNED <b>12-15-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-15-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>West Plains, Missouri</b>		
24. FUNERAL DIRECTOR <b>Glenn Carter West Plains, Mo</b>				ADDRESS	25. DATE RECD. BY LOCAL REG <b>Beatrice Cook</b>	26. REGISTRAR'S SIGNATURE <b>12-19-59</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 28 1959

FEB 2 1960

STATEMENT BY LICENSED EMBALMER

DEC

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

*Leland Carter*

Licensed Embalmer No. 4516

P. O. Address West Plains

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.