

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002140

FILED VS FEB 5 1960

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 46

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>JASPER</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOPLIN</b>		Length of stay in 1b <b>55 YRS</b>	c. CITY OR TOWN <b>JOPLIN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DOA FREEMAN HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>2530 ADELE AVE.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LORAN PARKER</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 26, 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1900</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER &amp; DECORATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LOUGHERTY PAINT Co.</b>		11. BIRTHPLACE (City and state or country) <b>ARKANSAS</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>GEORGE PARKER</b>		13b. MOTHER'S MAIDEN NAME <b>MAY GRAY</b>		14. NAME OF HUSBAND OR WIFE <b>MINOLA PARKER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNK</b>	17. INFORMANT Address <b>MRS. MINOLA PARKER, 2530 ADELE AVE.</b>			
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>Myocardial Infarction</b> DUE TO (b) <b>Coronary atherosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>14 yrs.</b>	
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		
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 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 <u>12/4/59</u> to <u>1/26/60</u> and last saw <sup>her</sup> him alive on <u>1/15/60</u> Death occurred at <u>4:45 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>A.K. Williams M.D.</b> (Degree or title)			22b. ADDRESS <b>301 Medical Arts Bldg. Joplin, Missouri</b>		22c. DATE SIGNED <b>1/28/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-29-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OSBORNE MEMORIAL,</b>		23d. LOCATION (City, town, or county) <b>JOPLIN, MISSOURI</b> (State)		
24. FUNERAL DIRECTOR <b>STEVE PARKER MORTUARY, JOPLIN, MO.</b> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <b>Feb. 1-1960</b>	26. REGISTRAR'S SIGNATURE <b>Nooe Merriam</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin Mo

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.