

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015559

FILED VS MAY 5 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2144

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 56 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2224 Lawn		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle S. Last Parsons				4. DATE OF DEATH Month April Day 18, Year 1960						
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11/18/1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker			10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel		11. BIRTHPLACE (City and state or country) Syracuse, Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Andrew J. Parsons			13b. MOTHER'S MAIDEN NAME Alice Inge			14. NAME OF HUSBAND OR WIFE Clara M. Parsons				
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. 487-05-3988		17. INFORMANT Clara M. Parsons		Address 2224 Lawn			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia and circulatory failure DUE TO (b) Cancer of prostate DUE TO (c) metastatic involvement - lung Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 5 yrs?			
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 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 Feb. 60 to April 15, 1960 and last saw her/him alive on April 10, 1960 Death occurred at Trinity Hospital on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) Houghton F. White MD				22b. ADDRESS 4620 Nichols Parkway			22c. DATE SIGNED 4-17-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Apr. 18, 1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery			23d. LOCATION (City, town, or county) Sedalia, Missouri					
24. FUNERAL DIRECTOR Earp & Sons				ADDRESS Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 4-17-60		26. REGISTRAR'S SIGNATURE Neva Marshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Houghton F. White

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 William H. Eyr

Licensed Embalmer No. 4728

P. O. Address H.C. 2

-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.