

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037449

FILED VS OCT 31 1960

38

Registration District No. 3006 Registrar's No. 598

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>13 days</u>		c. CITY OR TOWN <u>Cameron</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>640 Park</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Ray Parrack</u>				4. DATE OF DEATH Month Day Year <u>October 26, 1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>10-12-12</u>	9. AGE (last birthday) <u>47</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed interior decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interior decorator</u>		11. BIRTHPLACE (City and state or country) <u>Stover, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>D. Samuel Parrack</u>			13b. MOTHER'S MAIDEN NAME <u>Brockway</u>		14. NAME OF HUSBAND OR WIFE <u>Fannie Parrack</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Hospital chart U. of Mo. Med. Center</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>Cerebral hypoxia</u> DUE TO (c) <u>Cerebral edema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic maxillary sinusitis</u> <u>Carcinoma of lung with cerebral metastases</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <u>10/11/60</u> to <u>10/26/60</u> and last saw her/him alive on <u>10/26/60</u> Death occurred at <u>8:10 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>John H. Legan M.D.</u>				22b. ADDRESS <u>U. of Mo. Med Center Columbia Mo.</u>		22c. DATE SIGNED <u>10/26/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVABLE</u>	23b. DATE <u>10/26/60</u>	23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City, town, or county) <u>CAMERON MISSOURI</u>		(State)		
24. FUNERAL DIRECTOR <u>PARKER'S FUNERAL SERVICE</u>		ADDRESS <u>COLUMBIA MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 26, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 10 1960

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 George A. Kerf

Licensed Embalmer No. 4752

P. O. Address Columbia,

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.