RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 14 1960

-60-039421
STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 44587 Registrar's No. 63

DED

1. PLACE OF DEATH
a. COUNTY St Clair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lowry City — Length of stay in 1b 6 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY St Clair
c. CITY OR TOWN Osceola — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) Route 3 — Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First STELLA Middle O Last KNIGHT
4. DATE OF DEATH Month Oct Day 26 Year 1960
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH 8-1-83
9. AGE (last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) St Clair Co Mo
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Rufus Parks
13b. MOTHER'S MAIDEN NAME Mince Parks
14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 500-40-8389
17. INFORMANT Address Ralph Knight Osceola Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH Sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocarditis — History
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Stomach & Liver.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1948, to Oct. 26 1960 and last saw her/him alive on Oct. 26, 1960
Death occurred at 10:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] D.O.
22b. ADDRESS Lowry City Mo.
22c. DATE SIGNED 10-30-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-30-60
23c. NAME OF CEMETERY OR CREMATORY Kidds Chapel
23d. LOCATION (City, town, or county) (State) Osceola Mo Rt 3

24. FUNERAL DIRECTOR ADDRESS Goodrich Home Osceola Mo
25. DATE RECD. BY LOCAL REG. 11-4-60
26. REGISTRAR'S SIGNATURE Ruth [signature]

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3038

P. O. Address Osceola

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