

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004951

AMENDED Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 19 STATE FILE NUMBER

FILED VS FEB 27 1961

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| 1. PLACE OF DEATH a. COUNTY <u>Dent</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem</u> | | Length of stay in 1b <u>8 yrs</u> | c. CITY OR TOWN <u>Salem</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>at residence</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>North ain</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A</u> Last <u>Parsons</u> | 4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1961</u> |
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| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-17-87</u> | 9. AGE (last birthday) <u>73</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>general work</u> | 11. BIRTHPLACE (City and state or country) <u>Jonesboro Ark</u> | 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> |
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| 13a. FATHER'S NAME <u>Jim Parsons</u> | 13b. MOTHER'S MAIDEN NAME <u>-- Walker</u> | 14. NAME OF HUSBAND OR WIFE <u>May Judd</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>x</u> | 17. INFORMANT <u>Herb Parsons</u> Address <u>Salem Mo</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per (a); (b); and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY HEMORRHAGE</u> INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Pulmonary Infection - ? etiology</u> |
| | DUE TO (c) <u>Possible Pulmonary tumor - UNDIAGNOSED</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>chronic bronchitis</u> | |
| 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 | |

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| 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.) |
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| 20c. TIME OF INJURY Hour, . . . Month, Day, Year a.m. . . . p.m. . . . | 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 <u>Salem</u> COUNTY <u>MO</u> STATE <u>MO</u> |
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| 21. I attended the deceased from <u>2/10/61</u> to <u>2/19/61</u> and last saw <u>her</u> alive on <u>2/18/61</u> Death occurred at <u>4:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>B. J. Bass, MD</u> (Degree or title) | 22b. ADDRESS <u>Salem, Mo</u> | 22c. DATE SIGNED <u>2/20/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 23b. DATE <u>2-22-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Redmon Cem</u> | 23d. LOCATION (City, town, or county) (State) <u>Howell Co. Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Spencer Funeral Home Inc</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>2/20/61</u> | 26. REGISTRAR'S SIGNATURE <u>M. M. Clark, M.D.</u> |
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

MAR 7 1961

STATEMENT BY LICENSED EMBALMER

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 Carl H. Spitzer
Licensed Embalmer No. 2370
P. O. Address Palmer St

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.