

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-015994
STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1008

FILED APR 24 1961

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>VALLEY PARK</u>		c. CITY OR TOWN <u>VALLEY PARK</u>	
Length of stay in lb <u>6 YRS.</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>FORREST & WYNSTAY AVES</u>		d. STREET ADDRESS (If outside, give location) <u>FORREST & WYNSTAY AVES</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CLAUDE</u> Middle <u>P</u> Last <u>PARSONS</u>			4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1961</u>		
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5. SEX <u>M HLG</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>7-10-1895</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HERMAN BODY CO</u>	11. BIRTHPLACE (City and state or country) <u>VERGINIA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>JOHN M. PARSONS</u>	13b. MOTHER'S MAIDEN NAME <u>unk.</u>	14. NAME OF HUSBAND OR WIFE <u>HATTIE PARSONS</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. _____	17. INFORMANT <u>HATTIE PARSONS</u> Address <u>VALLEY PARK</u>
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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>CANCER OF PYRIFORMSINDS WITH CERVICAL METASTASES.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

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
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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.) _____
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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 _____
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21. I attended the deceased from JAN 4, 1961 to APRIL 7 and last saw ^{her}him alive on April 7
Death occurred at 3 AM April 12, 1961 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph H. Ogawa MD</u>	22b. ADDRESS <u>640 SKINGSIDE HWY S.W.</u>	22c. DATE SIGNED <u>April 14, 1961</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4-14-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d. LOCATION (City, town, or county) (State) <u>KNOXVILLE, TENN.</u>
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24. FUNERAL DIRECTOR <u>JAY B. SMITH</u> ADDRESS <u>MAPLEWOOD, MO</u>	25. DATE RECD. BY LOCAL REG. <u>4-12-61</u>	26. REGISTRAR'S SIGNATURE <u>John P. Murphy MD.</u>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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 W P Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.