

MISSOURI DIVISION OF HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-041295

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5804

STATE FILE NUMBER

AMENDED

FILED DEC 11 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF Hubert M. Parker MEDICAL CERTIFICATION

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) Kansas City		Length of stay in 1b 19 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 St. Mary's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 604 East 41st Street	
3. NAME OF DECEASED (Type or print) First FRANK Middle LIONEL Last TAYLOR			4. DATE OF DEATH Month November Day 18 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1891	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Internal Revenue Dept.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) England	
12. CITIZEN OF WHAT COUNTRY U. S. A.			13a. FATHER'S NAME George W. Taylor		
13b. MOTHER'S MAIDEN NAME Mary M. Williams			14. NAME OF HUSBAND OR WIFE None		
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. None		17. INFORMANT Miss Ethel E. Taylor Address Kansas City, 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) Cerebral Thrombosis					INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerosis					years
DUE TO (c) Pyelonephritis					2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Parkinson's Disease; Prostate tumor					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 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.)		
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 8-6-49 to 11-18-61 and last saw him alive on 11-18-61 Death occurred at 3:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Hubert M. Parker M.D.			22b. ADDRESS 928 Argyle Bldg.		22c. DATE SIGNED 11-20-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-21-61	23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 11-20-61		26. REGISTRAR'S SIGNATURE Ruth Long	

The Parker
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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 *J. P. Freeman*

Licensed Embalmer No. 293

P. O. Address *F. O. M.*

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.