

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-031461-
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 393

DO NOT WRITE ON THIS STUB

AMENDED

FILLED AUG 20 1962	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>	
Length of stay in 1b <u>12 Yrs.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Independence Sanatorium</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
c. CITY OR TOWN <u>Sugar Creek</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>400 No. Sterling</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LARRY WAYNE Parker</u>	
4. DATE OF DEATH Month Day Year <u>August 17, 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-1945</u>
9. AGE (last birthday) <u>17</u>	
IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>VAN HORNE High School</u>	
11. BIRTHPLACE (City and state or country) <u>Branswick, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William F. Parker</u>	
13b. MOTHER'S MAIDEN NAME <u>Ollie Bell Broke</u>	
14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs. Ollie Bell Parker - 400 N. Sterling</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u>	
Conditions, if any, which gave rise to above cause (e), 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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>apparently accidental shot himself</u>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>8-17-62</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Sugar Creek Jackson Mo</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Ben C. Koelby, M.D. Deputy County</u>	
22b. ADDRESS <u>6627 Park to D's Creek</u>	
22c. DATE SIGNED <u>8-17-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>8-20-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Washington Independence Missouri</u>	
23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR ADDRESS <u>Sheil Funeral Home - K.C., Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>8-19-62</u>	
26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 Thomas A. Shiel

Licensed Embalmer No. 4954

P. O. Address K. P. M. U.

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.