

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-031642

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 65

FILED AUG 17 1962

VS 300 Rev. 4/59	DATE AMENDED
1 <u>0542</u>	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
2 <u>0542</u>	
3 <u>2</u>	
4 <u>0</u>	
5 <u>2</u>	
6	
7 <u>0</u>	
8 <u>2</u>	
9 <u>3222</u>	
10	
11	INSTEAD OF
12 <u>1290-3</u>	DOCUMENT
13 <u>3-0</u>	
	MEDICAL CERTIFICATION
	BY AFFIDAVIT OF
	ITEM NO.
	SHOULD READ

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington		Length of stay in 1b lifetime	c. CITY OR TOWN Lexington Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 15th. & Franklin		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 319 Highland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLIFTON Middle LEONARD Last PARKS			4. DATE OF DEATH Month August Day 4 Year 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 18, 1897
9. AGE (last birthday) 65		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) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Gen'l Construction	11. BIRTHPLACE (City and state or country) Lexington, Mo
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME John William Parks	
13b. MOTHER'S MAIDEN NAME Caroline Knoeller		14. NAME OF HUSBAND OR WIFE unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. I		16. SOCIAL SECURITY NO. None	17. INFORMANT Miss Carrie Parks Lexington, Mo Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Deconferata Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Asates DUE TO (c) Alcoholism			INTERVAL BETWEEN ONSET AND DEATH unknown
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? NO	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 checked="" 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 after death to _____ and last saw him alive on none Death occurred at 7:00A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. Martin W. Croner (Degree or title)		22b. ADDRESS Odessa, Mo.	22c. DATE SIGNED 8-6-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/6/62	23c. NAME OF CEMETERY OR CREMATORY Machpelah Cemetery	23d. LOCATION (City, town, or county) (State) Lexington Mo.
24. FUNERAL DIRECTOR Vaughn-Walker Lexington, Mo. ADDRESS _____		25. DATE RECD. BY LOCAL REG. 8-6-62	26. REGISTRAR'S SIGNATURE Marion E. ...

USE BLACK INK OR TYPEWRITER RIBBON

AUG 17 1962

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 Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Leighton, Mo

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.