

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Clinton

Township _____ Registration District No. 206 File No. 786

Village _____ Primary Registration District No. 4174 Registered No. 5

City Lattrop (NO. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Tisdale Parshall

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Jan 26, 1911
(Month) (Day) (Year)

DATE OF BIRTH July 27, 1844
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 27, 1911, to Jan 26, 1911, that I last saw him alive on Jan 26, 1911, and that death occurred, on the date stated above, at 11:40 P.M.

AGE 66 yrs. 6 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Bowel Obstruction

OCCUPATION (a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 3-01

12 1/2 (Duration) ___ yrs. ___ mos. ___ ds.
136 P (Duration) ___ yrs. ___ mos. ___ ds.

BIRTHPLACE (City or town, State or foreign country) McClintock, Pa.

PARENTS
NAME OF FATHER James Parshall
BIRTHPLACE OF FATHER (City or town, State or foreign country) Fayette Co. Pa.
MAIDEN NAME OF MOTHER Hannah Caldern
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Fayette Co. Pa.

Contributory Stricture
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) [Signature] M. D.
1911 (Address)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. K. Parshall
(ADDRESS) Clearfield Iowa

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence

Filed Jan 28, 1911, Clint County REGISTRAR

PLACE OF BURIAL OR REMOVAL Lattrop DATE OF BURIAL Jan 28, 1911
UNDERTAKER T. G. Klepper Lattrop ADDRESS

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Clinton
Township Lathrop
or Village Lathrop
or City _____

Registration District No. 206 File No. 786
Primary Registration District No. 4124- Registered No. 5

(NO. _____) (St. _____) (Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Tisdale Parshall

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
DATE OF BIRTH 7/22/844
AGE 66 yrs. 6 mos. 4 ds. IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) _____

DATE OF DEATH _____, 1911
(Month) 1/26 (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from 1-22-1911, to 1-26-1911, that I last saw him alive on 1-26-1911, and that death occurred, on the date stated above, at 11:40 pm.
The CAUSE OF DEATH* was as follows:

Bowel Impaction
(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) McLettentown Pa
NAME OF FATHER Geo Parshall
BIRTHPLACE OF FATHER (City or town, State or foreign country) Hayette Pa Pa
MAIDEN NAME OF MOTHER Annabelle Aldrich
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Hayette Pa Pa

Contributory (SECONDARY) Structure
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) O. M. McCandless M. D.
Jan 28 1911 X (Address) Lathrop Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Parshall
Clearfield Pa.
(ADDRESS)
Filed Jan 28 1911 O. M. McCandless REGISTRAR

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted If not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Lathrop DATE OF BURIAL 1-28, 1911
UNDERTAKER T. G. Klepper ADDRESS Lathrop

All information called for must be written on this Supplementary Certificate.

JAN

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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