

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

Do not use this space.

761

1. PLACE OF DEATH *Home*  
 County..... Registration District No. *213*  
 Township..... Primary Registration District No. *3014*  
 City *Jefferson*, (No. ....) St. .... Ward.....  
 2. FULL NAME *James E. Parrish*  
 (a) Residence. No. *909 Meridian* St., .... Ward. *Fourth* *Mo*  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. *15* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Divorced*  
 5A. IS MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *J. L. Parrish*  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 10-1852*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min. *68* | *6* | *18*  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *Housework*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *at home*  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Macon* (STATE OR COUNTRY) *Mo*  
 10. NAME OF FATHER *Richard Asken*  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Mo* (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER *AK*  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT *J. J. Callender* (Address) *909 Meridian*  
 15. FILED *1.29.29* *Sub. Bldg.*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 28 1929*  
 17. I HEREBY CERTIFY, That I attended deceased from *1/28* 19*29*, to *1/28* 19*29*, that I last saw him alive on *1/25* 19*29*, and that death occurred, on the date stated above, at *100* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Relapse following pneumonia (lobar)*  
*113*  
*108* (duration) yrs. mos. ds.  
 CONTRIBUTORY *Influenza* (SECONDARY) (duration) yrs. mos. ds. *1* *10*

18. WHERE WAS DISEASE CONTRACTED *Work known*  
 NOT AT PLACE OF DEATH?  
 DID AN OPERATION PRECEDE DEATH? *no* DATE OF  
 WAS THERE AN AUTOPSY? *no*  
 WHAT TEST CONFIRMED DIAGNOSIS? *Physical Exam*  
 (Signed) *Wm. B. ...*  
 , 19 (Address) *Jefferson City, Mo*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Parson City, Mo* DATE OF BURIAL *1/30 29*  
 20. UNDERTAKER *Navson & Tanner* ADDRESS *J. C. Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
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REGISTERED

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Call Registration District No. 213 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3014 Registered No. \_\_\_\_\_  
 City Jefferson (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Harriet E. Parrish

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10 - 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
72 6 18

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.
- (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.
- (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

14.

INFORMANT \_\_\_\_\_  
 (Address)

15.

FILED 1-29-29 S. W. Budge  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 28 1929 19

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A. B.—Every item of information should be carefully & applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS IS A PERMANENT RECORD

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