

DEC 22 1930

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

Do not use this space.

36521

1. PLACE OF DEATH
 County Jasper Registration District No. 411
 Township Salena Primary Registration District No. 2202
 City Joplin No. _____ St. _____ Ward _____

2. FULL NAME Charles W. Parrish
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 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.

File No. _____
 Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wife Parrish

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 5 1845

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>85</u>	<u>10</u>	<u>11</u>		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) New York
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Wm Rice Parrish

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York
 (STATE OR COUNTRY) _____

12. MOTHER'S NAME Emeline Parker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New York
 (STATE OR COUNTRY) _____

14. INFORMANT Mrs F W Parrish
 (Address) Golden mo

15. FILED 11/18 1930 Abner Clark
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-16 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1930, to Nov 16 1930 that I last saw him alive on Nov 16 1930 and that death occurred, on the date stated above, at 5-35 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Natural Causes - Prosoy
Cerebral hemorrhage
82 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 74 (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) Lang Simmons M. D.
Nov 16 1930 (Address) Coroner's office

*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 <u>Frankford Kansas</u>	DATE OF BURIAL <u>11-18 1930</u>
20. UNDERTAKER <u>Wurlding Co</u>	ADDRESS <u>Joplin mo</u>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. 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.

