

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.

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

18028
Do not use this space.

REC'D JUN 14 1939

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township Washington Primary Registration District No. 1001 Registered No. 467
 (c) City St Joseph Mo (d) Street No. Mo. St. Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Synthia Parsons (PARSONS)
 (a) Residence, No. Albany Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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 R. F. Parsons
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. Est. 85
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind
 FATHER 13. NAME Gov. Garrett
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind
 MOTHER 15. MAIDEN NAME Garrett
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind
 17. INFORMANT (ADDRESS) G. D. Garrett
 18. BURIAL, CREMATION, OR REMOVAL PLACE Alma St DATE May 3 39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. E. Taggart
King City Mo
 20. FILED May 1 1939 St. Joseph Mo Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 1 1939
 22. I HEREBY CERTIFY, That I attended deceased from Apr 24 1939 to May 1 1939
 I last saw him alive on May 1 1939. Death is said to have occurred on the date stated above, at 5 a m.
 The principal cause of death and related causes of importance were as follows:
Coronary occlusion
93C
 Other contributory causes of importance:
chy lymf condition
arteria sclerosis
 Name of operation ✓ Date of
 What test confirmed diagnosis? clinical exam Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury , 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify H. H. Walker
 (Signed) H. H. Walker (Address) 301 N. St Joseph Mo, M. D.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

R. L. Taggart

Licensed Embalmer No. 25-63

P. O. Address King City 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 this body is not embalmed, above space should be left blank.