

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

24875
 Do not use this space.

AUG 14 1939

1. PLACE OF DEATH
 (a) County Adair Registration District No. 9
 (b) Township Butternut Primary Registration District No. 300 Registered No. 179
 (c) City Hubbardsville (d) Street No. _____ (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 James Edward Parsons
 (a) Residence, No. 416 N. Main St. (If nonresident, give city, or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emma Parsons

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 18, 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
	<u>73</u>	<u>5</u>	<u>5</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labourer
 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) Jackson Co. W. Virginia

FATHER
 13. NAME Thomas R. Parsons
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

MOTHER
 15. MAIDEN NAME Elizabeth Ann Braden
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

17. INFORMANT Frankie Hamilton (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL PLACE Spring no DATE July 25 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Spencer & Meenan Hubbardsville Mo.
 20. FILED July 25 1939 Spencer & Meenan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 23 1939

22. I HEREBY CERTIFY, That I attended deceased from June 27 1939, to July 23 1939
 I last saw him alive on Set July 22 1939. Death is said to have occurred on the date stated above, at 11:15 P.M.
 The principal cause of death and related causes of importance were as follows:
Cardiac Failure, acute nephritis, Carcinoma of Prostate.

Date of onset 51

Other contributory causes of importance: _____

Name of operation none Date of _____
 What test confirmed diagnosis? Urinalysis, by test, etc. 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 _____)
 (Signed) Joseph E. Bishop, M.D.
 (Address) Travelers Hotel, Hubbardsville, Mo.

RECEIVED

District Health Officer No. 10

District File Number 8-39-1460

Date Filed AUG-10-1939

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.....

Licensed Embalmer No.....

P. O. Address.....

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.