

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

33668
Do not use this space.

1. PLACE OF DEATH *2*

(a) County *Shelby* Registration District No. *830*

(b) Township *Salt River* Primary Registration District No. *6091*

(c) City _____ (d) Street No. _____ 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 *630 Robert Taylor Parrott*

(a) Residence, No. *Mexico 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Eliza Parrott*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 13 - 1849*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>89</i>	<i>10</i>	<i>17</i>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired*

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) *Ky 1*

FATHER

13. NAME *Jas W. Parrott*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky 1*

MOTHER

15. MAIDEN NAME *no record*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *no record*

17. INFORMANT (ADDRESS) *Sam G. Parrott*
Route 1 - Mexico Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE *Concedementary* DATE *Sept 2 - 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *E. P. Thompson*
Shelbyville, Mo.

20. FILED *Sept 2, 1939* *Ruth Joyner*
Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug - 30 - 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 28, 1939* to *Aug 30, 1939*

I last saw him alive on *Aug 28, 1939*. Death is said to have occurred on the date stated above, at *4:30 a.m.*

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Aug 27, 1939

82 lb

Other contributory causes of importance: _____

Name of operation *None* Date of _____

What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? *No* 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) *H. J. Spencer* M. D.
Shelbyville Mo.

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

RECEIVED

District Health Officer No. 10

District File Number 1039-1753

Date Filed OCT 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.....

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

Signed..... E. P. Thompson

Licensed Embalmer No..... 1632

P. O. Address..... Shelbyville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.