

DEC 12 1939

Registration District No. 325

Primary Registration District No. 1-150

Registrar's No. 6-8

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Walnut Grove  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 1 yr - 1 mo - 1 da (Specify whether years, months or days)

3. (a) PRINT FULL NAME George Edward Parrish

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept-17-1938  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 1 1 hr. \_\_\_\_\_ min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name MARION Parrish

13. Birthplace Polk County Mo  
(City, town, or county) (State or foreign country)

14. Maiden name WILMA Ross

15. Birthplace Polk County Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marion Parrish  
(b) Address Walnut Grove

17. (a) Burial (b) Date thereof Oct 18-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Edwin Turner  
(b) Address Walnut Grove

19. (a) Oct 20 - 39 (b) Etta B. McClure  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Walnut Grove (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. RFD # 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18  
year 1939 hour 4:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5-9-39  
\_\_\_\_\_ 19, to 9-18-39, 19;  
that I last saw him alive on 5-27-39, 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Congenital malformation of heart.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Esther Busch (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo Date signed 9/22/39

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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.

MOTHER FATHER

**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed.....

Licensed Embalmer No. 2668

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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39674

Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 325  
(b) Township Walnut Grove Primary Registration District No. 5400  
(c) City..... (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.

Registered No.....

2. PRINT FULL NAME

Geo. Edward Parrish  
(a) Residence, No.                      St.                       
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED                      (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 18 1939

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

22. I HEREBY CERTIFY, That I attended deceased from                      to                     , 1939

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

I last saw h.                      alive on                     , 19                    . Death is said to have occurred on the date stated above, at                      m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

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

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

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation..... Date of.....

15. MAIDEN NAME

What test confirmed diagnosis?..... Was there an autopsy?.....

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

17. INFORMANT (ADDRESS)

Accident, suicide, or homicide?..... Date of injury....., 19                    

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

Where did injury occur?..... (Specify city or town, county, and State)

19. FUNERAL DIRECTOR (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

20. FILED Oct 18 1939 EB McClure (by                     ) Local Registrar.

24. Was disease or injury in any way related to occupation of deceased?..... If so, specify                     

(Signed) Urban Basic, M. D.

(Address) Springfield Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY BOARD. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

