

FILED FEB 19 1940

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

4070

Do not use this space.

## 1. PLACE OF DEATH

(a) County TANEY Registration District No. 861  
 (b) Township Swain Primary Registration District No. 6132 Registered No. 8  
 (c) City \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. da. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mos. da.

2. PRINT FULL NAME B. D. A. L. PARRISH n - m - o

(a) Residence, No. \_\_\_\_\_ 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 MALE 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) NOV. 7, 1863

7. AGE YEARS 76 MONTHS 2 DAYS 27 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Carpenter  
 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) Polk County  
(STATE OR COUNTRY) Missouri13. NAME Barney P. Parrish14. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)15. MAIDEN NAME Emily16. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)17. INFORMANT Mrs. J. O. Parrish  
(ADDRESS) Forsyth, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Forsyth, Mo. DATE Feb 5, 194019. FUNERAL DIRECTOR (NAME) R. O. Whelchel  
(ADDRESS) Branson, Mo.20. FILED Feb. 4, 1940 Irene B. Reynolds  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 4 - 1940

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 3:30 p.m.

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

Patient appeared in bed suddenly. Had not received medical attention in last 2 months.

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) [Signature], M. D.(Address) Forsyth, Mo.

RECEIVED

District Health Officer No. 6,

District File Number 240-592

Date Filed FEB 15 1940

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **4070**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **861**

Primary Registration District No. **6132**

Registrar's No. **8**

1. PLACE OF DEATH:

(a) County **Igney**  
(b) City or town **Swan**  
(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 \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months & days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME **Abraham Linedu Parrish**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **4**  
year **1940**, hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

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

Immediate cause of death \_\_\_\_\_

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**96 2 27** hr. min.

Due to \_\_\_\_\_

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

Due to \_\_\_\_\_

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

Other conditions (include pregnancy within 3 months of death)

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

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

12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)

Of autopsy \_\_\_\_\_

14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Address \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: (Month) (Day) (Year)

(c) Where did injury occur? (City or town) (County) (State)

(c) Place: burial or cremation \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

(b) Address \_\_\_\_\_

Signature **J. M. Threadgill** (M. D. or other)

19. (a) **24-40** (b) **Drena B. Reynolds** (Registrar's signature)

Address \_\_\_\_\_ Date **Jan 7 1940**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

4070  
Do not use this spacer

1. PLACE OF DEATH  
(a) County Laney Registration District No. 861  
(b) Township Swain Primary Registration District No. 6132 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(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: Abraham Lincoln Parrish  
(a) Residence, No. Jermyth 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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>76</u>	MONTHS <u>2</u>	DAYS <u>22</u>	If LESS than 1 day, .....hrs. or .....min.
OCCUPATION	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	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED _____, 19____				

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-4, 1940

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

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

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

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) J. M. Threadgill, M. D.  
(Address) Jermyth mo

Local Registrar.

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