

WED MAR 12 1940

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

Do not use this space.

Hof: 16196
H.O.

1. PLACE OF DEATH

County Boyer Registration District No. 120
Township " Primary Registration District No. 3009
City Boyer Mo. (No. 0)

File No. _____
Registered No. 65
St. _____ Ward _____

2. FULL NAME

Grant Parrott

(a) Residence, No. 1424 Whitman St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 21-1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>74</u>	<u>3</u>	<u>25</u>	

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

9. Industry or business in which work was done, as silk mill, 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) Thebes Ill

13. NAME Wm. B. Parrott

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

15. MAIDEN NAME Anna E. Austin

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

17. INFORMANT Marjorie A Parrott (ADDRESS) Boyer Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Lorimer Cem DATE _____ 19 _____

19. UNDERTAKER Walther Und. Co. (ADDRESS) Boyer Missouri

20. FILED 2-16-40 J. M. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16-1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 7 1940 to Feb 16 1940

I last saw him alive on Feb 16 1940 Death is said to have occurred on the date stated above, at 10:30 a.m.

The principal cause of death and related causes of importance were as follows: Carcinoma of Pancreas Date of onset Unknown

Other contributory causes of importance: 46

Name of operating physician _____ Date of _____

23. If death was due to external cause (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 None

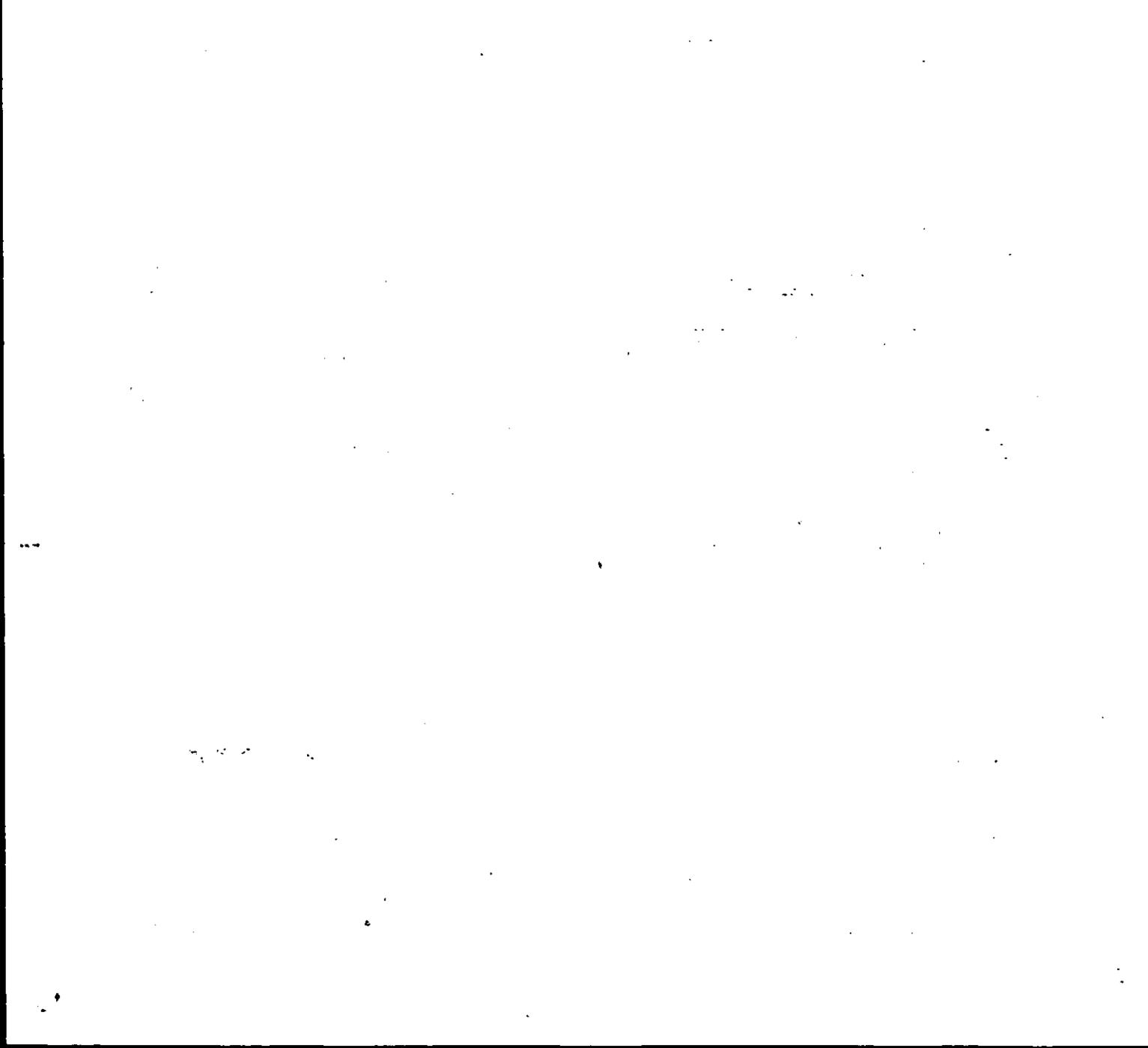
Nature of injury _____

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

(Signed) D. H. Hall M. D.

(Address) Boyer Missouri

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
STANDARD CERTIFICATE OF DEATH

State File No. **6196**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **125**

Primary Registration District No. **3009**

Registrar's No.

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

1. PLACE OF DEATH:
 (a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (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 _____ years, months or days)

3. (a) PRINT FULL NAME Grant Parrott
 (b) If veteran, name war _____
 (c) Social Security No. _____

4. Sex m 5. Color or race w
 6. (a) Single, widowed, married, divorced m
 (b) Name of husband or wife ESSIE
 (c) Age of husband, or wife, if alive _____ year
 7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 21
 If less than one day _____ hr _____ min.

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

10. Usual occupation: _____

11. Industry or business: _____

12. Name: _____

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

14. Maiden name: _____

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

16. (a) Informant: _____

(b) Address: _____

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

(c) Place: burial or cremation: _____

18. (a) Signature of funeral director: _____

(b) Address: _____

19. (a) 4-3-40 (b) gm Thompson
 (Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH: Month 2 day 16
 year 1970 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
 that I last saw h. _____ alive on _____ 19 _____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

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: D. H. Hope (M. D. or other) _____

Address: Cape Girardeau Mo. Date signed _____

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

SUPPLEMENTAL

