

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1147

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location) /
(d) Length of stay: In hospital or institution 12 days (Specify whether
In this community 3 1/2 yrs. years, months or days)

3. (a) PRINT FULL NAME JOSEPH PARRISH 6-20

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jennie Parrish 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased May 29 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 9 12 hr. min.

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

10. Usual occupation CITY EMPLOYEE

11. Industry or business PARK BOARD

MOTHER FATHER
12. Name JOHN PARRISH
13. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)
14. Maiden name NANCY ELLIS
15. Birthplace VIRGINIA
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jennie Parrish
(b) Address 1410 Wabash Ave.
17. (a) BURIAL (b) Date thereof 3-13-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT MORIAH.
18. (a) Signature of funeral director MELBODY M. GILLEY.
(b) Address K.C. Mo
19. (a) 3-15-40 (b) M. M. Browe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1410 Wabash
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11th
year 1940 hour 3 minute 40 P. M.

21. I hereby certify that I attended the deceased from 2-28-40, 19____, to 3-11-40, 19____;
that I last saw h im alive on 3-11-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary sclerosis; chronic myocardial infarction

Due to gates
Due to _____

Other conditions Pulmonary embolism
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 J. F. De Marco M.D. (M. D. or other) _____
Address Supt. K. C. Gen. Hospital, K. C. Mo. signed _____

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

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.

1938-1-11

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.