

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County Dunklin
 (b) City or town Smith
 (c) Name of hospital or institution: _____
 (If outside city or town limits, write "RURAL" and name of township)

(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 days3. (a) PRINT FULL NAME EMMA PARRISH

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race W- 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Geo Parrish 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased Aug 11 1900
 (Month) (Day) (Year)

8. AGE: Years 39 Months 6 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm. Henry McKeeney

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

14. Maiden name Mary Ann Kirby

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

16. (a) Informant's own signature Wm. Henry Brown

- (b) Address Smith, Mo.

17. (a) Smith Mo (b) Date thereof March 10 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Smith Mo

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) A. S. McDaniel
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Dunklin

- (c) City or town Smith
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9
 year 1940 hour 5 minute 39 P.M.

21. I hereby certify that I attended the deceased from March 9, 1940, to March 9, 1940
 that I last saw her alive on March 9, 1940
 and that death occurred on the date and hour stated above.

- Immediate cause of death Uremia Toxemia Duration 4-9-40

- Due to _____

- Due to Nephritis about 3 wks

- Other conditions _____
 (Include pregnancy within 3 months of death)

- Major findings: _____
 Of operations _____

- Of autopsy _____

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 Roy E. Meind (M. D. or other) _____

- Address Smith Mo Date signed 4-9-40

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RECEIVED

District Health Officer No.

District File Number 440-94

Date Filed 4/12/40

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. 10861

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 290

Primary Registration District No. 4174

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Agencia
(b) City or town: Senath
(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..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Emma Parish

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

4. Sex: 7 5. Color or race: W 6. (a) Single, widowed, married, divorced: W

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

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

8. AGE: Years: 39 Months: 6 Days: 27 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 9 year 1940 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: sepsis
sepsis 121

Due to.....

Due to: nephritis, chronic
None 6 mo

Other conditions: None
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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: Roy E Spardel (M. D. or other) D.
Address: Senath, Mo Date signed: 5-10-40

SUPPLEMENTAL

5-10861
1940