

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

3117  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County LEBANON Registration District No. 449  
 (b) Township LEBANON Primary Registration District No. 4267  
 (c) City LEBANON (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.

**2. PRINT FULL NAME**

William Edward Parson  
 (a) Residence, No. 220 Taylor Ave St.  Lebanon Mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 17, 1949  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
92 6 91 ... 2 ... 24

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. FARMER  
 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) 1936 11. Total time (years) spent in this occupation LIFE

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ENGLAND 4

FATHER 13. NAME SHADRICH PARSON  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ENGLAND 4

MOTHER 15. MAIDEN NAME UNKNOWN  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_ 9

17. INFORMANT MRS. BERT BARBER  
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL REMOVAL  
 PLACE CLINTON DATE Jan 11 1941

19. FUNERAL DIRECTOR FRED WILKINSON  
 (ADDRESS)

20. FILED 1-11-41 J. A. M. Comb  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11 1941  
 22. I HEREBY CERTIFY That I attended deceased from Nov 17 1940 to Jan 11 1941  
 I last saw him alive on Nov 21 1940. Death is said to have occurred on the date stated above, at 9:30 p.m.  
 The principal cause of death and related causes of importance were as follows:

"Flu" pneumonia Date of onset \_\_\_\_\_  
cardiac decompensation  
 Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

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? no  
 If so, specify \_\_\_\_\_  
 (Signed) G. L. Bohrer D.O. 2, M.D.  
 (Address) Lebanon 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.

I X12004

RECEIVED

District Health Officer No. 7

District File Number 3-41-368

Date Filed 2-13-41

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

\_\_\_\_\_ L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Fred Wilkins

Licensed Embalmer No. 2478

**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.)**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3117

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 449

Primary Registration District No. 4267

Registrar's No.

1. PLACE OF DEATH:

(a) County Levanon Laclede  
(b) City or town Levanon  
(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 or days)

3. (a) PRINT FULL NAME Wm Edw Parson  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year  
7. Birth date of deceased Oct 17 1849  
(Month) (Day) (Year)

8. AGE: Years 91 Months 2 Days 24 If less than one day..... 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) (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) 3-31-41 (b) J. M. Coult  
(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 Jan day 11  
year 1941 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) (c) Means of injury.....

23. Signature O. L. Bohrer (M. D. or other).....  
Address Levanon Mo Date signed.....

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

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

SUPPLEMENTAL

