

FILLED OCT 27 1941  
304

Primary Registration District No. 4185

Registrar's No. 41

## 1. PLACE OF DEATH:

(a) County Gentry  
 (b) City or town Albany  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (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 Mary Jane Parsons

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Wm. Parsons 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased February 28 1867  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>6</u>	<u>13</u>	hr. _____ min.

9. Birthplace Gentry County Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Homemaker

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

MOTHER FATHER  
 12. Name George McNeese  
 13. Birthplace Unk. Tennessee  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Jennie Hatcher  
 (City, town, or county) (State or foreign country)  
 15. Birthplace Unk. Unk.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nora Hanner(b) Address Albany, Mo.17. (a) Burial (b) Date thereof 9/13/41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Grandview18. (a) Signature of funeral director W. H. Martin  
Albany, Mo.(b) Address 198 1/2 N. 4th  
(Date received local registrar) (Registrator's signature)

(c) \_\_\_\_\_

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry  
 (c) City or town Albany  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 11  
year 1941 hour 9 minute 20 A. M.21. I hereby certify that I attended the deceased from 9-9-41  
to 9-11-41  
that I last saw her alive on 9-11-41  
and that death occurred on the date and hour stated above.

Immediate cause of death

Myocarditis

Duration

years.

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

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

Other conditions fracture left hip 2 days  
(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 038  
 (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 023. Signature Frank H. Rose (M. D. or other) M.D.  
Address Albany, Mo. Date signed 9-11-41

**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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Laufford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany Mo

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **34870**

Registration District No. **309**

Primary Registration District No. **4185**

Registrar's No. ....

1. PLACE OF DEATH:

(a) County **Gentry**  
(b) City or town **Albany**  
(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 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(d) Street No.....  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Mary J. Parson**

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

4. Sex **F** 5. Color **W** 6. (a) Single, widowed, married, divorced **m**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased **Feb 28** (Month) (Day) (Year)

8. AGE: Years **74** Months **6** Days **mo.** (If less than one day in 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)..... (b) Date thereof..... (Month) (Day) (Year)

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

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

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him alive on..... 19.....  
and that death occurred on the date and hour stated above  
Immediate cause of death **Myocarditis** Duration

Due to.....

Due to.....

Other conditions **Fracture Left hip** (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 **Sept 9 - 1941**  
(c) Where did injury occur? **Home** (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **yes** (Specify type of place) (c) Means of injury **fall**

23. Signature **Frank A. Rose** (M. D. or other) **M.D.**  
Address **Albany, Mo.** Date signed.....

**SUPPLEMENTARY**

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

