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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35764**
Registrar's No. **33791**

FILLED NOV 21 1941
Registration District No. **1941**

Primary Registration District No. **4404**

1. PLACE OF DEATH:
(a) County Phelps, *SWW*
(b) City or town St. James, Missouri
(c) Name of hospital or institution: Nettie McFarland Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ten days.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Cora Procilla 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 Clarence E. Parsons. 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August, 4th, 1919
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
22 1 7 hr. _____ min.

9. Birthplace Burnham, Missouri.
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife.

11. Industry or business Daniel B. Rice.
12. Name St James, Missouri
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name Alice Rice.
15. Birthplace St James, Missouri.
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs Alice Rice.
(b) Address St James, Missouri.

17. (a) Masonic Cemetery Date thereof 9-14-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St James, Missouri.
18. (a) Signature of funeral director Jordan & Son
(b) Address St James Mo. 14th
19. (a) 107-411 (b) Elmer B. Hough
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Phelps, 8/1
(c) City or town St James, Missouri. 3
(If outside city or town limit, 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 September 11th, 1941
year 1941 hour 2 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from July 1941
Sept. 11, 1941
that I last saw her alive on Sept. 11, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Abscess of brain 3 wks
Duration
Due to Influenza March 1941
(Abscess of lung)

Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy None
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 William H. Brewer (M. D. certifier)
Address St James Mo Date signed 9-13-41

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

81
30

RECEIVED

District Health Officer No. 5,

District File Number 10412030

Date Filed _____

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ILL
EAC

6847

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed

L. J. Jones

Licensed Embalmer No. 2579

P. O. Address Steelsville, 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, above space should be left blank.

FILE IN 117-117

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35 764
Registrar's No. 4404

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. James Sup.
(b) City or town St. James Sup.
(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

Sora Precilla Carson

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 m

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Aug.

(Month)

(Day)

(Year)

8. AGE:

Years 22

Months 1

Days

If less than one day

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 11 Year 1941 hour..... minute..... M.

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

Duration

Due to Influenza ? brain 13 hrs

Due to.....

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 William St. Brevel (M. D. or other) Address..... Date signed.....

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

SUPPLEMENTARY

S-35764