

No. 9-17-39 X29484

FILED AUG 7 1942

Registration District No. **8**

Primary Registration District No. **3007**

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

1. PLACE OF DEATH:

(a) County **BUTLER**
(b) City or town **POPLAR BLUFF**
(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 **6 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **BUTLER**
(c) City or town **POPLAR BLUFF**
(If outside city or town limits, write "RURAL")
(d) Street No. **131 No. E ST**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **JAMES EARL MACK PARROTT**

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

4. Sex **MALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife **—** 6. (c) Age of husband or wife if alive **—** years

7. Birth date of deceased **Dec 7 1929**
(Month) (Day) (Year)

8. AGE: Years **12** Months **7** Days **17** If less than one day **—** hr. **—** min.

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

10. Usual occupation **STUDENT**

11. Industry or business **—**

MOTHER FATHER { 12. Name **CHARLES MACK**
13. Birthplace **ARK 1**
(City, town, or county) (State or foreign country)
14. Maiden name **LUCILLE TURNER**
15. Birthplace **NEELYVILLE MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Lucille Parrott**
(b) Address **131 No. E St Poplar Bluff, Mo**
17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **JULY 26 1942**
(Month) (Day) (Year)
(c) Place: burial or cremation **NEELYVILLE CEM.**

18. (a) Signature of funeral director **A. J. Phelps**
(b) Address **Poplar Bluff, Mo**
19. (a) **7-25-42** (Date received local registrar) (b) **Bell Kinney** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **24**
year **1942** hour **11** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **July 23 1942** to **July 23 1942**
that I last saw him alive on **July 23 1942**
and that death occurred on the date and hour stated above.

Immediate cause of death **Spinal meningitis 10 day**
Duration

Due to **—**
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 **Frank E. Dwee** (M.D. or other) **D.P.D.**
Address **Poplar Bluff Hospital** Date signed **7/26/42**

RECEIVED

District Health Office No. 2,

District File Number 842-903

Date Filed 8-4-42

WASH DC
P. P. K.
F. J. F.

JAMES EARL RAY

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

N. P. Phelps

Licensed Embalmer No. 3231

P. O. Address

Caplan Bldg

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. 28961
Registrar's No. 231

Registration District No. 89 Primary Registration District No. 3007

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Poplar Bluff
(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 6 yrs years, months or days

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 _____

3. (a) PRINT FULL NAME James Earl Nick Parrott

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

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

8. AGE: Years _____ Months _____ Days _____ 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 _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-31-42 (b) Belle Anne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 24 year 1942 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 Spiral meningitis today
Due to now Epidemic

Due to _____

Other conditions _____ (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? _____

(Specify type of place) While at work _____ (e) Means of injury _____

23. Signature Frank B. Dwyer (M. D. or other) _____
Address Poplar Bluff Date signed 8/30/42

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

SUPPLEMENTARY

Tracer
Frank E. D. Wells, M.C.
P.O. Bluff