

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13179**
Registrar's No. **50**

Registration District No. **73**

Primary Registration District No. **4132**

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **Holt**
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Clay**
(c) City or town **Holt**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **U** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Thomas Marshal Parsons**

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

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Margaret Parsons** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **Oct 10 1884**
(Month) (Day) (Year)

8. AGE: Years **75** Months **6** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **Clinton Co Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business _____

12. Name **James Thomas Parsons**

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

14. Maiden name **Artie Marie Moberly**

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

16. (a) Informant **Maddlyne Parsons**

(b) Address **3601 Paris, K.C., Mo.**

17. (a) **Burial** (b) Date thereof **4-22-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Antioch**

18. (a) Signature of funeral director **Leonard Fry**

(b) Address **Kearney Mo**

19. (a) **April 22-45** (b) **Helen Carly**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April-20-45**
year **1945** hour **5** minute **30 A** M.

21. I hereby certify that I attended the deceased from **Jan-1-44** to **April-20-45**
that I last saw him alive on **April-20-45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart Attack**
Chronic myocarditis

Due to _____

Due to _____

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

Major findings: Of operations **930**
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 **C. B. Duntson** (M. D. or other) _____
Address **Roller Mo** Date signed **4-21-45**

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

RECEIVED

District Health Officer No. 8,

File Number.....

Filed 5/11/45

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..... Leonard Fry.....

Licensed Embalmer No..... 1677.....

P. O. Address..... Kearney 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.