

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 15 1946
Registration District No. 374

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4418**
Registrar's No. 2

Primary Registration District No. 4546

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Denver mo
(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 7 Days (Specify whether
In this community Three weeks years, months or days)

3. (a) PRINT FULL NAME JAMES WALLACE PARSONS

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Flora Parsons 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 22 1911 (Month) (Day) (Year)

8. AGE: Years 14 Months 2 Days 5 If less than one day hr. min.

9. Birthplace Clay Co mo (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name James Parsons
13. Birthplace Clay Co mo (City, town, or county) (State or foreign country)
14. Maiden name Ferry McLaugh
15. Birthplace Clay Co mo (City, town, or county) (State or foreign country)

16. (a) Informant Hellie Austin
(b) Address Denver mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Mize Cemetery

18. (a) Signature of funeral director Bruce Bros
(b) Address Denver mo

19. (a) Jan 6 1946 (Date received local registrar) (b) Leta E Dawson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Lentry 38
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27 year 1945 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from Nov 10 1945 to Nov 27 1945
that I last saw him alive on Nov 27 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary
Prostate Duration 2 weeks

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) Means of injury

23. Signature Charles H. Williamson M.D. or other mo
Address Lentry Date signed 12-5-45

745

(Licensed Embalmer's Statement on Reverse Side)

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

100942

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *J. P. Brown*

Licensed Embalmer No. 2747

P. O. Address.....

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.