

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED AUG 12 1946

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

28016
Do not use this space.

1. PLACE OF DEATH *Pike*

(a) County *Pike* Registration District No. *279*

(b) Township *Rural* Primary Registration District No. *5956* Registered No. *22 83*

(c) City *Rural* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Parson C. Mackey*

(a) Residence, No. *7 Pike Co.* St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widower*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *DEC. 25 - 1863*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	<i>82</i>	<i>7</i>	<i>9</i>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *farmer*

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pike Co. Mo*

FATHER

13. NAME *John D. Mackey*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pike - Co. Mo*

MOTHER

15. MAIDEN NAME *Elizabeth Brown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pike Co. Mo*

17. INFORMANT (ADDRESS) *Ethel Estes*
Clarksville Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE *Clarksville Mo.* DATE *Aug 5th 1946*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *N. E. Gooch*
Solia Mo.

20. FILED *F/11* 19 *46* *N. E. Gooch - Deputy*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug. 3 - 1946*

22. I HEREBY CERTIFY, That I attended deceased from *Oct 17 1945* to *Aug 3 1946*, 1946

I last saw him alive on *Aug 2 1946* Death is said to have occurred on the date stated above, at *2 P.M.*

The principal cause of death and related causes of importance were as follows:

Prostration
Chronic prostration years

Date of onset _____

Other contributory causes of importance: *107*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) *C. H. P. and head*, M. D.

(Address) *By nurse (M.D.)*

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 Norman E Gooch

Licensed Embalmer No. 2342

P. O. Address Colia - 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.