

FILED APR 14 1947

Registration District No. **120**

Primary Registration District No. **5444**

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

1. PLACE OF DEATH:

(a) County Stout
(b) City or town Boyer Athens 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 Lifelong
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stout **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 _____

3. (a) PRINT FULL NAME

William Ernoch Parsons

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex Male

5. Color or race W.

6. (c) Single, widowed, married 2 divorced widowed

6. (b) Name of husband or wife Elizabeth Parsons alive _____ years

6. (c) Age of husband or wife if _____

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 79 Months - Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation retired laborer

11. Industry or business _____

12. Name Wm E Parsons

13. Birthplace Stout Mo (City, town, or county) (State or foreign country)

14. Maiden name Fanny Hill

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

16. (a) Informant Ray Hill

(b) Address Albany Mo R. 7. D.

17. (a) Burial (b) Date thereof 3-21-47 (Month) (Day) (Year)

(c) Place: burial or cremation Long Star

18. (a) Signature of funeral director Robert R. Cook

(b) Address Albany Mo

19. April 1-1947 (b) James H. Melton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 19 year 1947 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from March 18 1947 to March 19 1947 that I last saw him alive on March 19 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 0

23. Signature J. N. Bergery (M. D. or other)

Address Albany Mo Date signed 3-25-47

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

**DISTRICT HEALTH OFFICE
Camden, Md.**

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 me.....

....., Registered Apprentice No.
working under my personal supervision.

Signed William Brooke.....

Licensed Embalmer No. 3329.....

P. O. Address Albany Md.....

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.