

FILED AUG 9 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22497

BIRTH NO. _____		REG. DIST. NO. <u>87</u>		PRIMARY REG. DIST. NO. <u>3005</u>		Registrar's No. <u>59</u>			
1. PLACE OF DEATH a. COUNTY <u>BATES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BATES</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>BUCHERILL</u>		c. LENGTH OF STAY (in this place) <u>4 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>RICH HILL</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BUTLER MEMORIAL HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>417 SPRUCE ST.</u>					
3. NAME OF DECEASED a. (First) <u>FRANCES</u>			b. (Middle) <u>ELIZIBETH</u>		c. (Last) <u>PARSONS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JULY--31-1949</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MARCH-4-1870</u>	9. AGE (in years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>DECATUR ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>WILLIAM T. HALL</u>			13b. MOTHER'S MAIDEN NAME <u>MARY JAMES</u>		14. NAME OF HUSBAND OR WIFE <u>AARON PARSONS (deceased)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. MINNIE PERKINS**</u> ADDRESS <u>RICH HILL, MO.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>fracture L. femur</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>E9040</u> <u>21</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Rich Hill Bates Mo.</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fall</u>					
22. I hereby certify that I attended the deceased from <u>July 30, 1949</u> , to <u>July 31, 1949</u> , that I last saw the deceased alive on <u>July 31, 1949</u> , and that death occurred at <u>5 a. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>L. S. LaFrie, M.D.</u>				23b. ADDRESS <u>Butler, Mo.</u>		23c. DATE SIGNED <u>8-2-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG. 3, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ADA CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ADA KANSAS</u>			
DATE REC'D BY LOCAL REG. <u>Aug-3-1949</u>		REGISTRAR'S SIGNATURE <u>Kendall Keran</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Booth Funeral Service</u>		ADDRESS <u>Rich Hill</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

mo.

RECEIVED

District Health Officer No. 7,

District File Number 7-49-963

Date Filed 8-8-49

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Robert G. Steinbeck

Licensed Embalmer No. 4657

P. O. Address Butte, 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.