

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 15 1950

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST.: NO. 282 PRIMARY REG. DIST. NO. 5976 Registrar's No. 315

1. PLACE OF DEATH a. COUNTY <u>POLK</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>POLK</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL</u>	
c. LENGTH OF STAY (in this place) <u>3492</u>		d. STREET ADDRESS (If rural, give location) <u>WALNUT GROVE #41, MO.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>WALNUT GROVE #41, MO</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>BENJAMIN</u> b. (Middle) <u>FRANKLIN</u> c. (Last) <u>PARRISH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 7, 1950</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DECEMBER 27, 1895</u>	9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>JOSEPH H. PARRISH</u>		13b. MOTHER'S MAIDEN NAME <u>ELLA KILLINGS WORTH</u>		14. NAME OF HUSBAND OR WIFE <u>HAZEN PARRISH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give year or date of service) <u>WW I</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>HAZEN PARRISH, WALNUT GROVE TRAIL MO</u> ADDRESS _____	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Coronary occlusion</u>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		_____		_____	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		_____	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____		_____	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS		_____	
Conditions contributing to the death but not related to the disease or condition causing death.		_____		_____	
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) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m.; from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Polk Co. Coroner</u>		23b. ADDRESS <u>Bolivar, Mo.</u>		23c. DATE SIGNED <u>3-11-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MARCH 9, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEMETERY</u>	
				24d. LOCATION (City, town, or county) (State) <u>POLK Co. Mo.</u>	

DATE REC'D BY LOCAL REG. <u>Mar. 11, 1950</u>		REGISTRAR'S SIGNATURE <u>Ralph Gardner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>TRON FUNERAL SERVICE, WALNUT GROVE MO.</u>	
---	--	--	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 1 1950

MAR 23 1950

RECEIVED  
District Health Officer No. 7  
District File Number 2-50-21  
Date Filed 3-24-50

**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.

Signed Warren D. Hobbs

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

Licensed Embalmer No. 4005

P. O. Address Chick Grove 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.