

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035631
STATE FILE NUMBER

FILED NOV 10 1958

XC-224,9062

REG. # 17308

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 670

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE MISSOURI b. COUNTY MISSISSIPPI)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ANNISTON
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL 15 DAYS		Length of stay in 1b 15 DAYS	0670 STREET ADDRESS BOX 216 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN TROY PARSONS			4. DATE OF DEATH Month Day Year OCTOBER 21, 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-94
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		9b. KIND OF BUSINESS OR INDUSTRY RELIGION	9. AGE (In years last birthday) 64 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY RELIGION	11. BIRTHPLACE (City and state or country) HERRIN, ILLINOIS
13a. FATHER'S NAME JAMES W. PARSONS		13b. MOTHER'S MAIDEN NAME ANNABELLE SIZEMORE	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. UNKNOWN	14. NAME OF HUSBAND OR WIFE CLEO E. PARSONS
17. INFORMANT VA HOSPITAL RECORDS, POPLAR BLUFF, MO.			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION.			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ACUTE MYOCARDIAL ISCHEMIA.			15 DAYS
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE.			8 YEARS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. attended the deceased from October 6, 1958 to Oct. 21, 1958 Death occurred at 5:25 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert S. Cohen		22b. ADDRESS VA HOSP., Poplar Bluff, Mo.	22c. DATE SIGNED 10-22-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-21-58	23c. NAME OF CEMETERY OR CREMATORY Christopher
24. FUNERAL DIRECTOR Christopher, Ill.		23d. LOCATION (City, town, or county) (State) Christopher, Ill.	25. DATE RECD. BY LOCAL REG. 10/31/58
		26. REGISTRAR'S SIGNATURE R. Amstreet	

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WILLIAM W. MUNGLE

EMBALMER

STATEMENT

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

Signature of Student Embalmer

Signed *Charles E. Mungle*

Licensed Embalmer No. 4877

P. O. Address *Bellevue, Wash.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

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