MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 13 1959

59-035481
STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 167

1. PLACE OF DEATH
a. COUNTY: CASS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Harrisonville
Length of stay in 1b: 1 DAY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Memorial Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: CASS
c. CITY OR TOWN: Harrisonville
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 800 Green St.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Eugene Last: Parris
4. DATE OF DEATH: Month: Nov Day: 4 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4-25-1958
9. AGE (last birthday): 1
IF UNDER 1 YEAR: Months 10 Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Allen Gene Parris
13b. MOTHER'S MAIDEN NAME: Helen L. Street
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No-
17. INFORMANT: Allen Parris Address: Harrisonville 800 Butler – Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 6 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): CONGENITAL HEART DISEASE
DUE TO (c): (TYPE UNKNOWN) — 22 MOS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

BY AFFIDAVIT OF

21. I attended the deceased from Nov. 4 1959, to Nov. 4 1959 and last saw him alive on Nov. 4 1959
Death occurred at 2:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: J. Moody M.D. (Degree or title)
22b. ADDRESS: Harrisonville Mo.
22c. DATE SIGNED: 11-5-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-7-1959
23c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
23d. LOCATION (City, town, or county) (State): Harrisonville, Missouri
24. FUNERAL DIRECTOR: Atkinson-Dicky ADDRESS: Harrisonville Mo.
25. DATE RECD. BY LOCAL REG.: 11-6-1959
26. REGISTRAR'S SIGNATURE: Mrs. Gay Sebree

(Licensed Embalmer's Statement on Reverse Side)

VS SEP 26 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Robert Atkinson

Signature of Student Embalmer

Licensed Embalmer No. 4902

P. O. Address Hammond

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.