

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS NOV 17 1959**

**5260**

**59-040287**

STATE FILE NUMBER

RECEIVED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Jackson</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>75 Yrs.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Grosse Nursing</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>3918 Charlotte</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ELLIS</b> Middle <b>DWIGHT</b> Last <b>PARSONS</b>	4. DATE OF DEATH Month <b>Oct</b> Day <b>31</b> Year <b>1959</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/1881</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	11. BIRTHPLACE (City and state or country) <b>Colorado</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Erskine D. Parsons</b>	13b. MOTHER'S MAIDEN NAME <b>Un known</b>	14. NAME OF HUSBAND OR WIFE <b>Emely Parsons</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>497-36-5763</b>	17. INFORMANT Address <b>G. L. Parsons, 25 W. 59th K. C. Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertensiv C V disease</b>	
	DUE TO (c) <b>auric. fibrillation</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>C. V. A. - Thrombo Styes Hyp. Partial 7 years</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from **8-8-51** to **10-31-59** and last saw <sup>her</sup> him alive on **10-31-59**  
Death occurred at **10 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Frank H. Lettz</b> (Degree or title) <b>MD</b>	22b. ADDRESS <b>1530 17th Pl Kansas City Mo</b>	22c. DATE SIGNED <b>11-2-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 3, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure, Kansas City, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>11-2-59</b>	26. REGISTRAR'S SIGNATURE <b>Neal Marshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank H. Lettz

**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 William M. Fournier

Licensed Embalmer No. 4648  
P. O. Kansas City

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.