

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 7 1960

-60-031553

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 301

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Pettis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		a. STATE <u>Mo</u>		b. COUNTY <u>Pettis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		Length of stay in 1b <u>40 yrs</u>		c. CITY OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>421 W. Broadway</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>ELLA</u>		Middle <u>JANE</u>		Last <u>PARRISH</u>		Month <u>Sept</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH <u>3-30-1869</u>		9. AGE (last birthday) <u>91</u>	
		Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>				IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (City and state or country) <u>Pettis Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Gen. W. Parrish</u>				13b. MOTHER'S MAIDEN NAME <u>Emira Jane Marshall</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>487-20-0570</u>		17. INFORMANT <u>Myra McFarland Sedalia</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u>						<u>7 hours</u>	
DUE TO (b) <u>Acute Congestive Heart Failure</u>						<u>7 hours</u>	
DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile dementia</u>				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			
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.)			
20c. TIME OF INJURY Hour <u>9:30</u> a.m. <u>P</u> Month, Day, Year <u>1960</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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. I attended the deceased from <u>9:30</u> <u>P</u> <u>1960</u> to <u>Sept 1</u> <u>1960</u> and last saw her <u>him</u> alive on <u>Sept 1</u> <u>1960</u>				Death occurred at <u>9:30</u> <u>P</u> <u>1960</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>D. L. Walter M.D.</u>				22b. ADDRESS <u>Sedalia Mo</u>		22c. DATE SIGNED <u>Sept 2-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-3-'60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>	
24. FUNERAL DIRECTOR <u>McLaughlin Bros</u>		ADDRESS <u>Sedalia</u>		25. DATE RECD. BY LOCAL REG. <u>9-3-1960</u>		26. REGISTRAR'S SIGNATURE <u>Tranese Shelby</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed K.P.M. Leary

Licensed Embalmer No. 3153

P. O. Address Sedalia

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.