

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041142

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Holt</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph, Mo</u>		Length of stay in lb <u>1 week</u>	c. CITY OR TOWN <u>Mound City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo Methodist Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>-</u> Last <u>Parrett</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3, 1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Common Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labourer</u>		11. BIRTHPLACE (City and state or country) <u>Olathe, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mary P. Parrett</u>	
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>None</u>		17. INFORMANT <u>Robt. Parrett</u> Address <u>5226 Rosemeade, Fresno River, Calif.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic gangrene RV lower leg 2wk</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized Arteriosclerosis</u>	
	DUE TO (c)	
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. <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>5:00</u> p.m. Month, Day, Year <u>11-4-60</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 <u>St. Joseph Mo</u> COUNTY <u>Holt</u> STATE <u>Missouri</u>
21. I attended the deceased from <u>11-4-60</u> to <u>11-14-60</u> and last saw him alive on <u>11-14-60</u> Death occurred at <u>5:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>E. F. Butler</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>902 Edmond St. Joseph Mo</u>	22c. DATE SIGNED <u>11-16-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>11/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Liberty</u>	23d. LOCATION (City, town, or county) (State) <u>Holt Co. Missouri</u>

24. FUNERAL DIRECTOR <u>James H. Crawford</u> ADDRESS <u>Mound City Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 16, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>
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DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

E. F. Butler, M.D.

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 James P. Crawford

Licensed Embalmer No. 4-796

P. O. Address Moving Co

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