RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 1 9 1960

5911 60-046267
STATE FILE NUMBER

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

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b: 10 years
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 504 S. Benton Benton Nursing Home — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Kansas City Mo. — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 514 West 9th — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First William Middle T. Last Parrott
4. DATE OF DEATH: Month Nov. Day 23 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10/14/72
9. AGE (last birthday): 88
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY: Operated Barbershop
11. BIRTHPLACE (City and state or country): Buckner, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Thomas Parrott
13b. MOTHER'S MAIDEN NAME: Minerva ~~Waikes~~ Walker
14. NAME OF HUSBAND OR WIFE: Emma Konard Parrott
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.: —
17. INFORMANT: Dewey Parrott, Address: Lexington, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 10 years
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. ☐ 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

21. I attended the deceased from 6-1-60, to 11-23-60 and last saw her/him alive on 11-23-60
Death occurred at 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Frank Paul Laurenzano (Degree or title) MD
22b. ADDRESS 428 S. White Ave
22c. DATE SIGNED 11-23-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Nov. 25, 1960
23c. NAME OF CEMETERY OR CREMATORY: Odessa Cemetery
23d. LOCATION (City, town, or county) (State): Odessa, Mo.
24. FUNERAL DIRECTOR: Husman-Sparks ADDRESS: Odessa, Mo.
25. DATE RECD. BY LOCAL REG.: 11-24-60
26. REGISTRAR'S SIGNATURE: H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT — MEDICAL CERTIFICATION

DEC 21 1960

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No.____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed William T. Sp

Licensed Embalmer No. 44

P. O. Address Odess

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