MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

21770

1 PLACE OF DEATH

County: Jefferson

Township:

City: Hillsboro

Registration District No. 422 File No. 21770

Primary Registration District No. 4250 Registered No.

(NO. , St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Henrietta C. Parkinson

PERSONAL AND STATISTICAL PARTICULARS

SEX:

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): widow

DATE OF BIRTH: July (Month) 18 (Day), 1844 (Year)

AGE: 82 yrs. 11 mos. 24 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION (Trade, profession, or particular kind of work): housework

(b) General nature of industry (business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Indiana

10 NAME OF FATHER: James Little

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Frazier

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Maryland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Octavia Burchanan

(Address) Hillsboro Mo

Filed Jul 12, 1927. Way Evans Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 12 (Month) (Day), 1927 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 8, 1927, to July 11, 1927, that I last saw h. alive on July 11, 1927, and that death occurred, on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH* was as follows:

Senile Mel
Hypostatic Pneu
[illegible]

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

, 191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death: yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Hillsboro Cem. DATE OF BURIAL: July 14, 1927

20 UNDERTAKER: C. Barnhart ADDRESS: Vineta Mo

MISSOURI STATE BOARD OF HEAL
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occ hospital or give its NAM of street and

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191

17 I HEREBY CERTIFY, that I attended deceas

....., 191....., to .....

that I last saw h..... alive on ....., 19

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Ca (1) Means of Injury; and (2) whether Accidental, Suicidal or Hon

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIA

20 UNDERTAKER	ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

PLACE OF DEATH

County Jefferson Registration District No. 422 File No.

Township Primary Registration District No. 4250 Registered No.

City Hillsboro (No. St. Ward)

NAME Henrietta C Parkinson

Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
6 DATE OF BIRTH	W	Wid

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR)

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS
BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)
NAME OF FATHER
BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
MAIDEN NAME OF MOTHER
BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

INFORMANT
(Address)

FILED July 12, 1927 Way Evans
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senility with Hypostatic pneumonia
Bronchopneumonia
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(SECONDARY)
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. M. Mockber, M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-21770