

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

18308
Do not use this space.

RECD JUN 15 1939

1. PLACE OF DEATH

(a) County Cass Registration District No. 162
 (b) Township Peculiar Primary Registration District No. 5-27
 (c) City Peculiar (d) Street No. 256 Registered No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 2 yrs. 3 mos. - ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Frank Eleworth Parrish
 (a) Residence, No. _____ St. _____ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 19, 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Parrish

22. I HEREBY CERTIFY, That I attended deceased from April 12, 1939, to May 18, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 25 - 1865

I last saw him alive on May 18, 1939. Death is said to have occurred on the date stated above, at 12 m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 2 24

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

Chronic Myocarditis
to myocardial degeneration
 Date of onset April 12-39

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

Other contributory causes of importance: Chronic Myocarditis 1936

FATHER 13. NAME Henry Parrish

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

MOTHER 15. MAIDEN NAME Dont Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

17. INFORMANT (ADDRESS) P. F. Parrish
Harrisonville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Peculiar DATE 5/20, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. H. Harrisonville, Mo.

20. FILED 5/19, 1939 Walter Robbins, M.D. Local Registrar.

Name of operation None Date of _____
 What test confirmed diagnosis? Chol. Rep. Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Signature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
 If so, specify _____ (Signed) W. H. Harrison, M.D.
 _____ (Address) Harrisonville, Mo.

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.

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 _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Ernest R. Runnenbeyer

Licensed Embalmer No. 3368

P. O. Address Harrisonville

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 this body is not embalmed, above space should be left blank.