DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31551

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3649

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K. C. Gen. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 815 E. 31st St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Edward Parsons 625

3. (b) If veteran, name war World War

3. (c) Social Security No. No

4. Sex M

5. Color or race W.

6. (a) Single, widowed, married, divorced D.

6. (b) Name of husband or wife Ink

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased April (Month) 28 (Day) 1910 (Year)

8. AGE:

Years	Months	Days	If less than one day
29	4	19	..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Mo (State or foreign country)

10. Usual occupation Salesman

11. Industry or business

FATHER
12. Name Wm F. Parsons
13. Birthplace Dout Knowe (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dout Knowe
15. Birthplace Dout Knowe (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Genl Hosp
(b) Address K. C. Mo

17. (a) St Louis Mo (Burial, cremation, or removal) (b) Date thereof 9/18/39 (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director W. F. Mayberry
(b) Address K. C. Mo

19. (a) Sept 18 1939 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1939 hour 9 minute 10 a M.

21. I hereby certify that I attended the deceased from 9-13, 1939 to 9-17, 1939; that I last saw him alive on 9-17, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	
Due to	
Due to 10 a	
Other conditions Chronic alcoholism (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy None	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature P. F. De Maria M.D. (M.D. or other)
Address Supt K. C. Gen Hosp Date signed 9-18-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 1 X19511

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.....

Licensed Embalmer No.....

P. O. Address.....

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.