

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15774

Registration District No. 667 Primary Registration District No. 5888 Registrar's No. \_\_\_\_\_ State File No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Johnson  
(b) City or town Rural  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
In this community 50 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Johnson  
(c) City or town Rural  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAMES James Robert Parrott

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 4 1848  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>92</u>	<u>2</u>	<u>17</u>	hr. _____ min. <u>0</u>

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name John Glenn Parrott 1  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Rogers  
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Sam Parrott  
(b) Address Idalia Colorado

17. (a) Rural (b) Date thereof Apr-23-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation City Cem. R. Mo.

18. (a) Signature of funeral director C. L. Sauls

(b) Address West North Mo.

19. (a) 4-22-40 (b) B. J. Turner  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21  
year 1940 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 19, 1940 to April 21, 1940  
that I last saw him alive on April 21, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage (24)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Chronic Bronchial Pneumonia  
(Include pregnancy within 3 months of death) (Myocardial Infarction)

Major findings: none  
Of operations \_\_\_\_\_  
Of autopsy none

Duration  
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? \_\_\_\_\_

(e) Means of injury \_\_\_\_\_  
(Specify type of place)

23. Signature Paul Groves (M. D. or other) MD  
Address West North Mo Date signed Apr 22 1940

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

**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 \_\_\_\_\_

D. R. Saultb

Registered Apprentice No. 249

working under my personal supervision.

Signed C. L. Saultb

Licensed Embalmer No. 1086

P. O. Address Knob Noster M

**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.**