

No. 2  
1-4-41  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10677

State File No. \_\_\_\_\_

Registration District No. 170

Primary Registration District No. 5630

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Rural  
(c) Name of hospital or institution:  
R#2 Lebanon mo 1  
(d) Length of stay: In hospital or institution Neither  
In this community Always

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Laclede  
(c) City or town Rural  
(d) Street No. R#2 Lebanon  
(e) Citizen of foreign country? no  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EDNA PATSONS

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Melvin S. Parsons 6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased April 3 1879

8. AGE: Years 63 Months 11 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Laclede Co. Mo.

10. Usual occupation House wife

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

MOTHER FATHER { 12. Name W. H. Mizer  
13. Birthplace Tenn  
14. Maiden name Mary E. Clark  
15. Birthplace Ark.

16. (a) Informant M. S. Parsons

(b) Address R#2 Lebanon mo.

17. (a) Burial (b) Date thereof 3-28-43

(c) Place: burial or cremation Balls

18. (a) Signature of funeral director Palmer

(b) Address Lebanon mo.

19. (a) 4-4-43 (b) Grace Roper

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25 year 1943 hour 9 minute 40 P.M.

21. I hereby certify that I attended the deceased from Lebanon 26 1943 to March 28 1943 that I last saw him alive on March 28 1943 and that death occurred on the date and hour stated above

Immediate cause of death Cerebral failure Duration \_\_\_\_\_

Due to hemorrhage stroke

Due to Concussion of brain, rupture, loss of life

Other conditions (Include pregnancy within 3 months of death) Myocardial lesion

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Justin Palmer (M. D. or other) M.D.  
Address 109 Monroe Lebanon Date signed 3/29/43

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

Received APR 6 1943  
LaClede County Health Unit  
File No. 3-42-46  
Date Filed APR 7 1943

**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 Allyn DeTherage  
Licensed Embalmer No. 4393  
P. O. Address Sebanon Mo.

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10677  
Registrar's No. \_\_\_\_\_

Registration District No. 170

Primary Registration District No. 5630

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Edna Parsons

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased April 3 (Month) (Day) (Year)

8. AGE: Years 63 Months 11 Days 22 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_  
11. Industry of business \_\_\_\_\_

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day \_\_\_\_\_ year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to Carcinoma, primary in cervix  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury ?  
23. Signature Justin B. Brown (M. D. or other) D.O.  
Address Lelanon, Mo. Date signed 5/6/43

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-10677