

FILED AUG 8 1944

Registration District No. **318** Primary Registration District No. **100** Registrar's No. **6622**

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 67 Days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME JAMES C. PARRISH

3. (b) If veteran, name war no

3. (c) Social Security No. 702-02-5280

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife Mable Parrish

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased March 29 1906
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>38</u>	<u>4</u>	<u>6</u>	hr. min.

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

10. Usual occupation Signal maintenance

11. Industry or business Mo. Pac. R.R.

12. Name James O Parrish

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

14. Maiden name Ellie Haggard

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

16. (a) Informant Mable Parrish

(b) Address Pacific, Mo.

17. (a) Burial (b) Date thereof 7/30/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cuba, Mo.

18. (a) Signature of funeral director J. J. Brueck
(b) Address _____

19. (a) JUL 28 1944 (b) J. J. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

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

(d) Street No. _____
(If rural, give location) N.R.

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27
year 1944 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from July 1
1944 to July 27 1944
that I last saw him alive on July 27 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Meningitis Pneumonia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 81

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature J. J. Brueck (M. D. or other) M.D.
Address 4952 Maryland Date signed 7/28/44

SEP 5 1947

OCT 24 1945

AUG 23 1944

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 *John L. Shieles*

Licensed Embalmer No. *3008*

P. O. Address *Pacific No.*

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.