No. 2
9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

26904

FILED AUG 22 1945

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 856

1. PLACE OF DEATH:

(a) County Buchanan County
(b) City or town St. Joseph, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 2 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution State Hospital (Specify whether
In this community 2 Yrs. 1 Mo. 14 Days.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 11
(c) City or town Kansas City, Missouri 1
(If outside city or town limits, write "RURAL")
(d) Street No. 3114 Poplar Street 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Waller Davis Parrish

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 1

5. Color or race White

6. (a) Single, widowed, married, divorced Wid. 2

6. (b) Name of husband or wife Olevia J. Hicks

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

7. Birth date of deceased February (Month) 16 (Day) 1861 (Year)

8. AGE: Years 84 Months 5 Days 19 If less than one day hr. min.

9. Birthplace Columbia, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Machinist, Woodworker, Watch repairman - Handyman.

11. Industry or business

FATHER
12. Name John Parrish
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mildred Waller
15. Birthplace Kentucky 1
(City, town, or county) (State or foreign country)

16. (a) Informant Cora Edith Lamb
(b) Address 3114 Poplar, K. C., Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-5-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City Mo.

18. (a) Signature of funeral director Walter Meilshoffer
(b) Address St. Joseph Missouri

19. (a) 8-5-45 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5th year 1945 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 19, 1945, 19, to August 5, 1945 that I last saw him alive on August 5, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia — Duration 3 days

Due to Fracture of Hip

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) No 131
(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 0

23. Signature George M. Botzler (M. D. ~~or other~~)
Address St. Joseph Mo. Date signed 8/5/45

1011 (Licensed Embalmer's Statement on Reverse Side)

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 Elbert L. Harrington

Licensed Embalmer No. 3258 Mo

P. O. Address St. Joseph, 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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 856

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(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 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 Walter D. Parrish

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. (Month) 16 (Day) 1861 (Year)

8. AGE: Years 84 Months 5 Days 19 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

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

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

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 5 year 1945 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

SUPPLEMENTARY

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence July 29 - 1945

(c) Where did injury occur? St Joseph (City or town) Buchanan (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? State Hospital #2 St Joseph Mo (Specify type of place)

While at work? No (e) Means of injury Fell from bed

23. Signature George M Boteler (M. D. or other)

Address St Joseph Mo Date signed 8/24/45

S-26904