V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32845

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4405

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~~: MENORAH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 9 DAYS (Specify whether
In this community 36 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

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

(d) Street No. 3711 FOREST AVENUE
(If rural, give location)

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

If yes, name country ----

3. (a) PRINT FULL NAME MRS MINNIE MARQUIS PARSONS

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband ~~or wife~~ MR ROBERT E PARSONS

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

7. Birth date of deceased JUNE (Month) 1 (Day) 1863 (Year)

8. AGE:

Years	Months	Days	If less than one day
82	4	23	hr. min.

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

10. Usual occupation AT HOME

11. Industry or business ----

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

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

16. (a) Informant MR. GENE MARQUIS

(b) Address 3711 FOREST AVENUE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT-27-1945 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ LEAVENWORTH KANSAS

18. (a) Signature of funeral director O. H. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 10-26-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 24TH year 1945 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from 10-15-45, 19__, to 10-24, 1945; that I last saw her alive on 10/24, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Colon c̄ complete obstruction

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death) 46e

Major findings:
Of operations

Of autopsy

Duration

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 [signature] (M. D. or other) MD

Address 1025 Prof. Bldg Date signed 10/25/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. [illegible]
Professional Bldg

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 H C Newcomer Jr

Licensed Embalmer No. 4043

P. O. Address K C 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.