

FILED MAR 18 1946 STANDARD CERTIFICATE OF DEATH.

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

Registration District No. 99

Primary Registration District No. 5378

Registrar's No. 12

1. PLACE OF DEATH:  
 (a) County DeKalb.  
 (b) City or town Union Star Mo. R.R.  
(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 years, months or days)  
 In this community All Life.

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County DeKalb. 32  
 (c) City or town Union Star Mo. R.R.  
(If outside city or town limits, write "RURAL") 0  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Ruben Parrish.  
 3. (b) If veteran, name war No. 3. (c) Social Security No. No.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Feb. day 12. year 1946 hour 7:30 minute P. M.

4. Sex Male 5. Color or Race Cau. 6. (a) Single, widowed, married, divorced single.  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov. 1871  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 1 1946 to Feb 12 1946 that I last saw him alive on Feb 12 1946 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
74 2 17 hr. min.

Immediate cause of death Cornary Occlusion  
 Due to Arterio Sclerosis

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

Due to \_\_\_\_\_  
 Other conditions Cornary Occlusion  
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer.

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

11. Industry or business same.

MOTHER FATHER { 12. Name James Parrish  
 13. Birthplace N.C.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Margaret E. Mathey.  
 15. Birthplace Kentucky.  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Wethel Jillson.  
 (b) Address Union Star Mo. R.R.

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? \_\_\_\_\_

17. (a) removal. (b) Date thereof 2.15.1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Joseph Mo.

18. (a) Signature of funeral director R. L. Taggart  
 (b) Address King City Mo.

23. Signature E. M. Reynolds (M. D. or other) \_\_\_\_\_  
 Address Union Star Mo Date signed 2-14-46

19. (a) 2-24-46 (b) Roscoe Davidson  
(Date received local registrar) (Registrar's signature)

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

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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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 J. B. G. Taggart

Licensed Embalmer No. 2563

P. O. Address King City 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.**