

No. 2  
12-45  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 20330

FILED JUL 14 1947

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 103

1. PLACE OF DEATH

(a) County Cass  
(b) City or town Harrisonville  
(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 40 yrs.  
In this community 40 yrs.  
years, months or days) (Specify whether)

3. (a) PRINT FULL NAME MARY HEDGER PARSONS

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

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wm. A. Parsons 6. (c) Age of husband or wife if alive 91 years

7. Birth date of deceased Dec 28 1875  
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Robert Allen Hedger

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

14. Maiden name E. Pless Clifford Hedger

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

16. (a) Informant Garret A. Parsons

(b) Address Harrisonville Mo.

17. (a) burial (b) Date thereof July 5 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Orient Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S  
(b) Address HARRISONVILLE, MO.

19. (a) July 7-1947 (b) Raura J. Jones  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cass 19  
(c) City or town Harrisonville /  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. 1100 E. Pearl St. 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5  
year 1947 hour 15:30 minute A 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.

Immediate cause of death Tuberculosis  
Croup Duration 2 yrs

Due to  
Due to

Other conditions 13 B  
(Include pregnancy within 3 months of death)

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) (c) Manner of injury

23. Signature E. M. Saffelt (M. D. or other)  
Address Harrisonville Date signed July 7/47

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

MOTHER FATHER

AUG 1 1947

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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.....

Licensed Embalmer No. 3368

P. O. Address Harrisonville

**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.**