

S. No. 2
M-5-43
v. 5-17-39
P I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40673

State File No. _____

FILED DEC 2 1947
Registration District No. 379

Primary Registration District No. 4573

Registrar's No. 27

1. PLACE OF DEATH:

(a) County SULLIVAN
(b) City or town Green Castle
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Cooley Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr (Specify whether
In this community Life years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County SULLIVAN
(c) City or town Green City, Castle
(If outside city or town limits, write "RURAL")
(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 PARSONS

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 Widowed

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

7. Birth date of deceased 8 2 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 3 18 hr. min.

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

10. Usual occupation Medical Doctor

11. Industry or business _____

12. Name Ephraim Parsons

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

14. Maiden name Eleanor Buford

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

16. (a) Informant Pete Parsons

(b) Address Green Castle

17. (a) Burial (b) Date thereof 11-23-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle

18. (a) Signature of funeral director Wm. H. Taylor
(b) Address Green City, Mo.

19. (a) 11-27-1947 (b) Anna Stacy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 20
year 1947 hour 4 minute P.M.

21. I hereby certify that I attended the deceased from Aug 1-1947
Nov 20 1947, 19____, to _____, 19____

that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Disease
of heart following a Parylitic
Stroke 7 years ago. Duration _____

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.

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) Means of injury _____

23. Signature W. H. Herington M.D. (M. D. or other) _____

Address Green City, Mo. Date signed 11-27-47

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

5-20

RECEIVED
District Health Officer No. 10
District File Number 12-47-1629
Date Recd. DEC-11-1947

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address. Green 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.