

FILED FEB 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3665

State File No.

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 24

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

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Miami "Rural" R 2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Fitzgibbon Memorial Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>6 mi S.W. Miami</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ALBERT</u> b. (Middle) <u>ROSS</u> c. (Last) <u>PARSONS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan-26-1949</u>
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5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>never married</u>	8. DATE OF BIRTH <u>June 3 - 1898</u>	9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Madison Parsons</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah (Jiles)?</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>never in army</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>H. C. Foote</u>	ADDRESS <u>Miami Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myeloma</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Interstitial Nephritis</u> DUE TO (c) <u>504 X</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>no</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1/25, 1949, to 1/26, 1949 that I last saw the deceased alive on 1/26, 1949 and that death occurred at 2:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title)	23b. ADDRESS <u>Marshall Mo</u>	23c. DATE SIGNED <u>1/26/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 31-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Dowdy</u>	24d. LOCATION (City, town, or county) (State) <u>Saline Co Mo</u>
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DATE REC'D BY LOCAL REG. <u>Jan 28-1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>385</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Hershberger</u>	ADDRESS <u>Marshall Mo</u>
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RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-3-49 _____

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Joseph R. Mackler _____

Signed _____
Student Embalmer

Licensed Embalmer No. 4571

P. O. Address Marshall, 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.