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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 25 1953

State File No. 14417

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1781

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): 53 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 3038 805 Pacific

3. NAME OF DECEASED (Type or Print)
a. (First): Calvin
b. (Middle):
c. (Last): PARRISH

4. DATE OF DEATH (Month) (Day) (Year): March 26 1953

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 14, 1881
9. AGE (In years last birthday): 72 — If under 1 year: Months ~~Days~~ — If under 1 hr.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and State or Foreign Country): NASHVILLE, TENN.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: —
14. NAME OF HUSBAND OR WIFE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: Bernice Williams
ADDRESS: 583 Harris

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic
ANTECEDENT CAUSES — DUE TO (b): Heart Disease
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

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: History taken from hospital
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:00 p.m., from the causes and on the date stated above.*

23a. SIGNATURE: Thos. A. Jones (Degree or title): M.D.
23b. ADDRESS: 1612 E. 12 St.
23c. DATE SIGNED: 3/27/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4/4/1953
24c. NAME OF CEMETERY OR CREMATORY: Highland
24d. LOCATION (City, town, or county) (State): K.C. Mo.

DATE REC'D BY LOCAL REG.: 4-1-53
REGISTRAR'S SIGNATURE: Geraldine Smith
25. FUNERAL DIRECTOR'S SIGNATURE: BRIGHAM & JONES
ADDRESS: 18th & Park

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Student .....
Student Embalmer

Signed Lawrence A. Jo

Licensed Embalmer No. 4429

P. O. Address 2300 East 187-

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.