

FILED SEP 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29805

State File No. 3937

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3937

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		c. LENGTH OF STAY (in this place) 4 1/2 yrs	c. CITY OR TOWN KANSAS CITY
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph's Hosp.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 6221 SWAPE PARKWAY		99 3749	

3. NAME OF DECEASED (Type or Print) a. (First) Le Roy	b. (Middle) H.	c. (Last) Parrott	4. DATE OF DEATH (Month) (Day) (Year) Sept 6 1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7-19-1886
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISPATCHER	11. BIRTHPLACE (City and State or Foreign Country) Jewel City, Kansas
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Yellow Cab Co.	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Parrott	13b. MOTHER'S MAIDEN NAME Johanna Terhoone	14. NAME OF HUSBAND OR WIFE Elizabeth Oliver PARROTT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO	16. SOCIAL SECURITY NO. 495-03-6075A	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Parrott
		ADDRESS 6221 Swape Pkwy

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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ch. Pyelonephritis - Pelvic Calculi		INTERVAL BETWEEN ONSET AND DEATH 610+
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Benign Prostatic Hypertrophy		
	DUE TO (c) Pulmonary Edema		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 _____ m., from the causes and on the date stated above.

23a. SIGNATURE H. Frank HOLMAN (Degree or title)	23b. ADDRESS St Joseph Hospital	23c. DATE SIGNED 9-7-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/8/55	24c. NAME OF CEMETERY OR CREMATORY Floral Hills
DATE REC'D BY LOCAL REG. 9-8-55	REGISTRAR'S SIGNATURE Neva Minsell	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
25. FUNERAL DIRECTOR'S SIGNATURE Sheil Funeral Home H.C. Mo.		ADDRESS Sheil Funeral Home H.C. Mo.

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.....
Signature of Student Embalmer

Signed *Richard E. Carroll*.....

Licensed Embalmer No. *484*.....

P. O. Address *K 28*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.