

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036550

STATE FILE NUMBER

FILED OCT 29 1958

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4846

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Trinity Lutheran 499a</u>		Length of stay in lb <u>499a</u>	d. STREET ADDRESS (If outside, give location) <u>1700 Vision Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>Francis</u> Last <u>Parrish</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>12</u> Year <u>1958</u>			
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5. SEX <u>MALE</u> <input checked="" type="checkbox"/> <input type="checkbox"/>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1908</u>	9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF-FARMER'S MUTUAL INSURANCE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>TOPEKA, KANSAS</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>JAY D. PARRISH</u>	13b. MOTHER'S MAIDEN NAME <u>Iva Mable Henslee</u>	14. NAME OF HUSBAND OR WIFE <u>LORA EVELYN PARRISH</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>YES</u> (known) (If yes, give war (Indicate service) <u>WW 2</u>)	16. SOCIAL SECURITY NO. <u>442-07-5731</u>	17. INFORMANT <u>LORA EVELYN PARRISH</u> Address <u>1700 Vision Rd</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>4000</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from <u>Nov 1950</u> to <u>October 12, 1958</u> and last saw him <u>live on Oct 12, 1958</u> Death occurred at <u>3:45 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Edw. H. Fischer, M.D.</u> (Degree or title) _____	22b. ADDRESS <u>306 E. 21st Wke 16 Mo</u>	22c. DATE SIGNED <u>10-17-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel</u>	23d. LOCATION (City, town, or county) (State) <u>Clay Co, Mo</u>
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24. FUNERAL DIRECTOR <u>D.W. Newcomer</u> ADDRESS <u>200 N. K.C.</u>	25. DATE RECD. BY LOCAL REG. <u>10-14-58</u>	26. REGISTRAR'S SIGNATURE <u>newcomer</u>
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All diseases in Part I must be causally related.

Edw. H. Fischer USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. Fischer

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Glenn H. Hill*

Licensed Embalmer No. *4586*

P. O. Address *K.C. 16. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.