

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Montgomery
Township DuSable
or
Village New Florence
or
City + (NO. _____ St. _____ Ward _____)

Registration District No. 593 File No. 2020

Primary Registration District No. 4351 Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Amos Palmer

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Widower
(Write the word)

DATE OF BIRTH April 28, 1872
(Month) (Day) (Year)

AGE 41 yrs. 8 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Barber
(b) General nature of Industry, business, or establishment in which employed (or employer) 2-11

BIRTHPLACE (City or town, State or foreign country) Lincoln Co. Mo.

PARENTS

NAME OF FATHER J. H. Palmer

BIRTHPLACE OF FATHER (City or town, State or foreign country) Lincoln Co. Mo.

MAIDEN NAME OF MOTHER Cannon

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lincoln Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. P. Wyatt

(ADDRESS) New Florence Mo

Filed Jan 4, 1913 B. F. Holcombe MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 1, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 20, 1912, to Jan-1, 1913, that I last saw him alive on Jan-1, 1913, and that death occurred, on the date stated above, at 6-P. M. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
82 A
82 D (Duration) 1 yrs. 3 mos. 3 ds.
Contributory Hemiplegia
(SECONDARY) (Duration) 2 yrs. 3 mos. 10 ds.

(Signed) F. P. Wyatt M. D.
Jan-1, 1913 (Address) New Florence Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted If not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL New Florence DATE OF BURIAL Jan 4, 1913

UNDERTAKER Am Wilson ADDRESS New Florence Mo

WITH ONE COPY OF THIS STATEMENT TO BE KEPT IN THE OFFICE OF THE REGISTRAR. THE STATEMENT SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. STATE OF DEATH IS PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



WHILE PLAINLY WRITTEN, THIS IS A PERMANENT RECORD

6. B.—Every statement of Informant should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Montgomery
Township _____
or
Village New Florence
or
City _____ (NO. _____ St.: _____ Ward)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 593 File No. _____
Primary Registration District No. 4357 Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Amos Palmer

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>m</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>wd</u>
DATE OF BIRTH <u>April 28, 1872</u> (Month) (Day) (Year)		
AGE <u>40 yrs. 8 mos. 3 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Barber</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Lincoln Co mo</u>		
PARENTS	NAME OF FATHER <u>J. H. Palmer</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>mo</u>	
	MAIDEN NAME OF MOTHER <u>Samson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Lincoln Co mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
_____ 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 20, 1912, to Jan 1, 1913, that I last saw live on Jan 1, 1913, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
or Wyatt says patient was slightly paralyzed for years and was able to move around, but mental attack occurred at 6 P. m. he became unconscious and was dead at 6 P. m.
Cerebral Neurotoxicity

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory Paraplegia
(SECONDARY) (Duration) 2 yrs. 3 mos. 10 ds.

(Signed) X F. P. Wyatt M. D.
March 7, 1913 (Address) New Florence

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted
If not at place of death? _____

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. P. Wyatt
(ADDRESS) New Florence

PLACE OF BURIAL OR REMOVAL <u>New Florence</u>	DATE OF BURIAL <u>Jan 4, 1913</u>
UNDERTAKER <u>O. M. Wilson</u>	ADDRESS <u>New Florence</u>

Filed JUAN H. HOLCOUBE 1913 REGISTRAR

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)