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

Do not use this space.

File No. 10695
Registered No. 2706

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St. Louis (No. St. Johns Hospital St. ..... Ward)

2. FULL NAME Donald Walter Palmer

(a) Residence. No. ..... St., 12 Ward. Festus Mo.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 16-1913

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	16	3	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Festus
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Walter J. Palmer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Clara Fidley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.

14. INFORMANT Leon A. Palmer
(Address) Festus Mo.

15. FILED MAR 17 1930 Max C. Starkloff
REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-15 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-26, 1930, to 3-15, 1930 that I last saw h. alive on 3-14 1930, and that death occurred, on the date stated above, at 8:45 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

108 Acute Cardiac Dilatation
90 B
95 B (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Acute Pneumonia Secondary
Pneumonia Lobar (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF ✓
WAS THERE AN AUTOPSY? ✓
WHAT TEST CONFIRMED DIAGNOSIS? Witness Post
(Signed) Alphonse M. Mahon M. D.
3/15, 1930 (Address) Mo. Theatre Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Bonne Terre Mo	3-17 1930
20. UNDERTAKER	**ADDRESS**
Gruestar & Vineyard	Festus Mo.

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