

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

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

SEP 14 1939 791

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27597  
Registrar's No. 7097

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH: 1008  
(a) County  
(b) City or town ST. LOUIS  
(c) Name of hospital or institution: 3231 EADS AV. 2  
(d) Length of stay: In hospital or institution (Specify whether years, months or days) 456

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County  
(c) City or town ST. LOUIS 16  
(d) Street No. 3605 Mc DONALD.  
(e) If foreign born, how long in U. S. A. years.

3. (a) PRINT FULL NAME STILLBORN PALMER  
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased AUG 15 1939 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace ST. LOUIS MISSOURI (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name LAWRENCE PALMER  
13. Birthplace ST. LOUIS MO. (City, town, or county) (State or foreign country)  
14. Maiden name GRACE RYAN  
15. Birthplace ST. LOUIS MO. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lawrence Palmer  
(b) Address 3605 Mc Donald av.  
17. (a) BURIAL (b) Date thereof AUG 1939 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary  
18. (a) Signature of funeral director E. J. Schum  
(b) Address 3125 Lafayette av.  
19. (a) AUG 15 1939 (b) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 15 year 1939 - hour 2:45 PM  
21. I hereby certify that I attended the deceased from Aug 10 1939, 19 Aug 16, 1939 that I last saw him alive on Dec 8/10, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death: 5 months heart failure  
Due to  
Due to  
Other conditions: arteriosclerosis  
Major findings: none  
Of operations  
Of autopsy: no

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence no  
(c) Where did injury occur? no (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no  
While at work? no (Specify type of place) (e) Means of injury none  
28. Signature Dr. F. H. Harrison (M.D. or D.V.M.)  
Address 2016 Lindell Street St. Louis, Mo. State Missouri

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**