

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31680
3728
Registrar's No. _____

Registration District No. 399
Primary Registration District No. 1002

1. PLACE OF DEATH: **JACKSON OCT 18 1939**
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 Days
In this community 7 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 4004 Troost Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Jean Frances Palmer 456
3. (b) If veteran, name was no
3. (c) Social Security No. no

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 21, 1932
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>7</u>	<u>3</u>	<u>2</u>	hr. _____ min. _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation School

11. Industry or business _____

MOTHER FATHER
12. Name James Y. Palmer
13. Birthplace Belleville, Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Virginia Bowers
15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jean Frances Palmer
(b) Address 4004 Troost Avenue

17. (a) Burial (b) Date thereof 9-25-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah
Freeman Mortuary

18. (a) Signature of funeral director _____
(b) Address Kansas City, Missouri

19. (a) Sept 25 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 23rd
year 1939 hour _____ minute 40 M.

21. I hereby certify that I attended the deceased from Sept 29, 1939 to Sept 23rd, 1939; that I last saw her alive on Sept 23rd, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death: Multiple abscesses of liver
Due to suppurative phlebitis portal vein
Due to strep infection
Other conditions no other
(Include pregnancy within 3 months of death)

Duration
12
15 days

Major findings: Of operations _____
Of autopsy the above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature J. W. Hallberg (M. D. or other) _____
Address 588 med arts K.C., Mo. Date signed 9/24/39

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.

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.....

Elmer C. Wedel

Licensed Embalmer No. *3495*

P. O. Address *Texas City*

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.