

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.

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

42925  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Callaway Registration District No. 104  
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 323  
 (c) City Fulton (d) Street No. State Hospital # 2 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 456 Susanna Palmer  
 (a) Residence, No. Moberly 170 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 13, 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>85</u>	<u>5</u>	<u>19</u>	<u>25</u>

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. Home  
 10. Date deceased last worked at this occupation (month and year) D.K. 11. Total time (years) spent in this occupation 40

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OKLAHOMA

FATHER

13. NAME James Hess  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.

MOTHER

15. MAIDEN NAME D.K.  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.

17. INFORMANT (ADDRESS) Hospit & Records.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Moberly DATE Dec 9th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mahan and Son Moberly Mo

20. FILED Dec. 8 1939 R. N. Creve  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 8 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 11 1939 to Dec. 8 1939  
 I last saw h. er alive on Dec. 8 1939 Death is said to have occurred on the date stated above, at 5:40 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Generalized Arteriosclerosis in def.  
95%  
 Other contributory causes of importance:  
Arteriosclerotic Heart Disease

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) J. R. Beech M. D.  
106 (Address) State Hospital # 1

**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..... *Frank S. DeWitt*

Licensed Embalmer No..... *3021*

P. O. Address..... *Molokai*

**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.**