

No. 2  
4-13-40  
5-17-39  
I X23155

NOV 19 1940

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:

(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: Jennett Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1  
(Specify whether)

In this community Non-Resident  
years, months or days

3. (a) PRINT FULL NAME Iva L. Palmer

3. (b) If veteran, Iva L. Palmer name war No

3. (c) Social Security No. No

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Roy Palmer

6. (c) Age of husband or wife if alive 35

7. Birth date of deceased: Oct - 8 - 1918  
(Month) (Day) (Year)

8. AGE: Years 29 Months 18 Days 18 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name Clara Eurdale

13. Birthplace Sard Kas.  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Eurdale

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Art Palmer

(b) Address 37 Marianne Road

17. (a) Entire (b) Date thereof 10-18-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garden Kansas

18. (a) Signature of funeral director C. A. Thurman

(b) Address 2512 Halton St

19. (a) 10-17-40 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte

(c) City or town 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 27 Marianne Road  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 37 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 14 year 40  
hour 11:55 minute P. M.

21. I hereby certify that Deceased the deceased from 11:55 P.  
10 to 19;

that I last saw Deceased alive on 10, 1940;

and that Deceased died on the date and hour stated above.

Immediate cause of death Subdural cerebral hemorrhage  
fracture of the base  
fracture of the skull  
with comminution

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Yes

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) Accident

(b) Date of occurrence 10-14-40

(c) Where did injury occur? K. C. (City or town) Mo (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place (in public place?) no

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury)

23. Signature Arthur Eurdale (M. D. or other)

Address K. P. Mo Date signed \_\_\_\_\_

210m  
86  
98  
Maid  
V.A.

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.

116  
66  
07 01

Signed P. G. Thruiser

Licensed Embalmer No. 2361

P.O. Address 2512 Holmes St

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21

Registrar's No. 3996

Registration District No. ....

Primary Registration District No. ....

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town K.C.  
(c) Name of hospital or institution: Gen. Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME Iva L. Palmer

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. year

7. Birth date of deceased. (Month) (Day) (Year)

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

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

14. Maiden name.

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

16. (a) Informant.

(b) Address.

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) 10/17/40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.  
(c) City or town. (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? years.

19. MEDICAL CERTIFICATION  
20. DATE OF DEATH. Month Dec. Day 14 - Year 40  
year. hour. minute. M.

21. I hereby certify that I attended the deceased from 19. to 19. that I last saw him alive and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage  
Laceration of brain  
Due to Fracture of knee  
Auto transport  
Due to Non collision Acc

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations. 7/10 MV  
ii  
20

Of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accid -  
(b) Date of occurrence 12-14-40  
(c) Where did injury occur? K. C. Mo. (City)  
(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. (M. D. or other) Address. Date signed

SUPPLEMENTARY

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

3-34480