MID NOV 20 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 35841

Registration District No. 561 Primary Registration District No. 5755 Registrar's No. 50

I X23159

6

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

**1. PLACE OF DEATH:**
(a) County Miller Salem Tp
(b) ~~City or town~~ Olean
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 15 years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Miller
(c) City or town Olean
(If outside city or town limits, write "RURAL")
(d) Street No. Main Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Mae Hannah Palmer

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife J. E. Palmer

6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased June (Month) 15 (Day) 1863 (Year)

8. AGE: Years 77 Months 3 Days 0 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name George Sanders
13. Birthplace (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Nancy Compton
15. Birthplace (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant J. E. Palmer
(b) Address Olean, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Jefferson City, Mo.

18. (a) Signature of funeral director Phillips Funeral Home
(b) Address Eldon, Missouri

19. (a) 9-16-1940 (Date received local registrar) (b) Belle Haynes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month September day 15 year 1940 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1938, 19.., to Sept 15, 1940 that I last saw her alive on Sept 14, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension & Nephritis

Due to (Parenchymatous)

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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? 475 (Specify type of place)
While at work? (e) Means of injury

23. Signature W. C. Allen (M. D. or other) MD
Address Eldon Date signed 11/7/40

(Licensed Embalmer's Statement on Reverse Side)

92W

RECEIVED
Miller County Health Dep't.
County File Number 40-99
Date Filed 11/12/40

**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 Louis D. Phillips, Registered Apprentice No. ____ working under my personal supervision.

Signed Louis D. Phillips

Licensed Embalmer No. 3663

P. O. Address Eldon

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

S. No. 2B
I—2-21-40
I X22659

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

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 35841

Registration District No. 561 Primary Registration District No. 5755 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Miller

(b) ~~City or town~~ Saline T.P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

**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.

3. (a) PRINT FULL NAME Mae Hannah 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 years

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

8. AGE: Years 77 Months 3 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 15 year 1940 hour minute M.

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

Immediate cause of death Cerebral Hemorrhage

Hypertension

Chronic nephritis

Due to Parenchymatous

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 131

Of autopsy

Duration

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

23. Signature W. L. Allee (M. D. or other)
Address Elaine Ks Date signed 9/16/40

SUPPLEMENTARY