V. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 31 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25885

Registration District No. 316 Primary Registration District No. 36075 Registrar's No.

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 yrs. 4 mos. 27 das. (Specify whether
In this community 2 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 94
(c) City or town St. Clair 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. Unknown
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME THORNTON PALMER

3. (b) If veteran, name war Unknown
3. (c) Social Security No. None

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed 2
6. (b) Name of husband or wife Kate
6. (c) Age of husband or wife if alive years
7. Birth date of deceased About (Month) (Day) 1868 (Year)

8. AGE: Years About 76 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) America (State or foreign country)
10. Usual occupation Common laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-44 (Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cem., Farmington, Mo.
18. (a) Signature of funeral director C. H. Cozean
(b) Address Farmington, Mo.
19. (a) 6-15-44 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4, year 1944 hour 1 minute 15 A. M.

21. I hereby certify that I attended the deceased from April 1k, 1944, 19__, to June 4, 1944, 19__; that I last saw him alive on June 4, 1944, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Thrombosis of superior mysenteric artery.	
Due to	
Due to	
Other conditions Chronic pericarditis (Include pregnancy within 3 months of death)	
Major findings: Of operations 90 b	
Of autopsy Thrombosis of superior mysenteric artery - Chronic pericarditis	

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 [signature] (M. D. or other) Nyl
Address 408 W First Farmington, Mo. Date signed 6-8-44

1373 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 744-4103
Date Filed 7-28-44

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.

Not embalmed

Signed .....

Licensed Embalmer No. 4084

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, fact should be so stated above.