

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

FILED JUN 10 1948

Registration District No. **272**

Primary Registration District No. **8907**

Registrar's No. **32**

1. PLACE OF DEATH:

(a) County **Pemissac**
(b) City or town **Stule**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **13 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pemissac**
(c) City or town **Stule** **3**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Maud Palmer**

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

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

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

7. Birth date of deceased **Aug 6 1886**
(Month) (Day) (Year)

8. AGE: Years **59** Months **7** Days **29** If less than one day hr. _____ min.

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

10. Usual occupation **House work**

11. Industry or business _____

12. Name **William Walls**

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

14. Maiden name **unknown**

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

16. (a) Informant **Cornal Palmer**
(b) Address **Stule Mo**

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

(c) Place: burial or cremation **Stule**

18. (a) Signature of funeral director **W. E. Palmer**
(b) Address **Stule Mo**

19. (a) **June 1 - 48** (b) **W. E. Palmer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **5**
year **1946** hour **2** minute **10 A.M.**

21. I hereby certify that I attended the deceased from **March 29**
1946 to **Apr. 5** 1946
that I last saw h. e. alive on **Apr 4**
and that death occurred on the date and hour stated above, 1946

Immediate cause of death **hypostatic pneumonia**

Due to **Diffuse metastatic carcinoma**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 **D. England** (M.D. or other) **20**
Address **Stule** Date signed **5/1/46**

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

MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
ST. LOUIS, MO.

5-46-108

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 John W. Herman

Licensed Embalmer No. 4355

P. O. Address Dayton, Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. June
Registrar's No. 32Registration District No. 272Primary Registration District No. 5907

1. PLACE OF DEATH:

(a) County Pemissic
 (b) City or town Steele
 (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
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME

Maud Parness3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex F 5. Color or race w 6. (a) Single, widowed, married,
divorced wid6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased aug 6
(Month) (Day) (Year)8. AGE: Years 59 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1946 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____
to _____, 19____

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of uterus Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy 48h

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 [Signature] (If not other) _____Address [Signature] Date signed 6/7/46

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

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

16466

17586