

FILED JAN 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

569

State File No. _____

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Missouri
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 10 Days (Specify whether _____)

In this community 10 Days
years, months or days

3. (a) PRINT FULL NAME Earl E. Palmer

3. (b) If veteran, name war World War II

3. (c) Social Security No. 492 18 2994

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased September 26 1909
(Month) (Day) (Year)

8. AGE: Years 37 Months 3 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation Cook

11. Industry or business _____

MOTHER FATHER

12. Name William Palmer

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

14. Maiden name Minnie McBee

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

16. (a) Informant Hospital Records, Veterans Administration Hospital

(b) Address Excelsior Springs, Missouri

17. (a) Removal (b) Date thereof 1-3-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Removed to: Kansas City, Missouri
Burial or cremation

18. (a) Signature of funeral director NEWCOMERS FUNERAL HOME

(b) Address Kansas City, Missouri

19. (a) 1/3/47 (b) Blairline Hutchings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1221 Olive (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2
year 1947 hour 4:45 minute _____ P. A. M.

21. I hereby certify that I attended the deceased from December 23, 19 46 to January 2, 19 47
that I last saw him alive on January 2, 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Pulmonary Chronic, far advanced, active
Duration Unknown

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy Same as above.

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? _____

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

23. Signature H. H. Kaplan (M. D. or other) MD
H. H. KAPLAN Clinical Director
Address Veterans Administration Hospital signed 1/3/47
Excelsior Springs, Mo.

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

RECEIVED
1780
AON

District Health Officer No. 8

District File Number

Date Filed 7-18-47

JAN 29 1947

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 *Emile M. Calhoun*

Licensed Embalmer No. 3506

P. O. Address *H. C.*

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.