

S. No. 2  
M-8.43  
7. 5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16466

State File No. \_\_\_\_\_

FILED JUN 12 1947

Registration District No. 31

Primary Registration District No. 4039

Registrar's No. 6

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

1. PLACE OF DEATH:  
 (a) County Butler  
 (b) City or town Lincoln  
 (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 entire life years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Butler  
 (c) City or town Lincoln  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Francis Palmer  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. no

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 22  
 year 1947 hour 7 minute 30 P.M.  
 21. I hereby certify that I attended the deceased from 5-15-47  
 to 5-22-47, 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Sarah Ellen Palmer  
 6. (c) Age of husband or wife if alive 91 years  
 7. Birth date of deceased Sept 30, 1854  
 (Month) (Day) (Year)

Immediate cause of death Hypostatic pneumonia  
 Due to Cerebral Apoplexy

8. AGE: Years Months Days If less than one day  
92 7 22 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Wagon Co (City, town, or county) no (State or foreign country)

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

10. Usual occupation Farmer

Major findings: Of operations 837  
 Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Lucius Palmer

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

14. Maiden name Lucille Leas

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

16. (a) Informant John Palmer

(b) Address Peterson Ridge, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation St. Pleasant

18. (a) Signature of funeral director Pres. Sumner

(b) Address Lincoln, Mo.

19. (a) 5-24-47 (Date received local registrar) (b) E. E. Eckhardt (Registrar's signature)

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 2

23. Signature G. W. Moulton (M. D. or other) Mo

Address Chic. Cant, Mo Date signed 5-24-47

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

RECEIVED  
District Health Officer No. 7,  
District File Number 5-47-702  
Date Filed 6-9-42

**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 F. Reser* .....  
Licensed Embalmer No. *4098* .....  
P. O. Address..... *Tharsaw* .....

**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.**