

FILED AUG 19 1947
Registration District No. **1002**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **30 days**
(Specify whether years, months or days) **unknown**

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. **2634 Lockridge**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Eugene Palmer**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **7**
year **1947** hour **5** minute **30 A.** M.

4. Sex **male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **unknown**
6. (c) Age of husband or wife if alive **12** years
7. Birth date of deceased **May 12 1902**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 8**, 19**47**, to **Aug. 7**, 19**47**, that I last saw him alive on **Aug. 7**, 19**47**, and that death occurred on the date and hour stated above.
Duration

8. AGE:	Years	Months	Days	If less than one day
	45	2	25	hr. min.

Immediate cause of death **Chronic glomerulonephritis**

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

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

10. Usual occupation **none**

Major findings:
Of operations.....
Of autopsy **None**

11. Industry or business.....
12. Name **William Palmer**
13. Birthplace **unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Edis Taylor**
15. Birthplace **Tenn**
(City, town, or county) (State or foreign country)

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.....

16. (a) Informant **Record Clerk**
(b) Address **K C Gen Hosp 1st**
17. (a) **Removal** (b) Date thereof **8-7-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **West Plains Mo**

23. Signature **Wm W Hart** (M. D. or other) **MD**
Address **Med. Dir. Gen'l Hosp** Date signed **8-7-47**

18. (a) Signature of funeral director **Wm W Hart**
(b) Address **West Plains Mo**
19. (a) **8-8-47** (b) **Seraldine Holmes**
(Date received local registrar) (Registrar's signature)

Dr. Lockwood.

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 A. Schreyer

Licensed Embalmer No. 3089

P. O. Address 15 C MD

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.