FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 20 1947

Registration District No. 128

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37777

Primary Registration District No. 2000

Registrar's No. 942

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield, (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: O'Reilly Veterans Administration Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5 mo. 24 days (Specify whether years, months or days)
In this community: same

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Barry
(c) City or town: Butterfield (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: PALMER, Leslie Clark
3. (b) If veteran, name war: WW One
3. (c) Social Security No.: Unknown
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: June (Month) 12 (Day) 1895 (Year)
8. AGE: Years 52 Months 4 Days 20 If less than one day hr. min.
9. Birthplace: Omaha (City, town, or county) Nebraska (State or foreign country)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Clyde E. Palmer
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name:
15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Correspondence Records
(b) Address: O'Reilly VAH, Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-3-47 (Month) (Day) (Year)
(c) Place: burial or cremation: National Cem
18. (a) Signature of funeral director: Gorman Scharff Funeral Home
(b) Address: Springfield Mo.
19. (a) 11-1-47 (Date received local registrar) (b) W. E. Hartley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 1 year 1947 hour 4 minute 25 P.M.
21. I hereby certify that I attended the deceased from 5/8/47, 19..., to 11/1/47, 19...; that I last saw him alive on 11/1/47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis, pulmonary, far advanced, active	
Due to:	
Due to:	
Other conditions: (Include pregnancy within 3 months of death) Diabetes mellitus	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause of 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: PAUL L. EISELE (M. D. or Coroner)
Address: O'Reilly VAH, Springfield Mo. Date signed: 11-1-47

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Lewis G Schaefer

Licensed Embalmer No. 3802

P. O. Address Springfield, 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.