

FILED APR 14 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10332

State File No. 3224

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3224		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY				
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis		2029		
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp.				d. STREET ADDRESS (If rural, give location) 5400 Rosa Ave.				
3. NAME OF DECEASED (Type or Print) ELIZABETH			a. (First)		b. (Middle) PALMER		c. (Last)	
4. DATE OF DEATH April 5 1950		(Month) (Day) (Year)		5. SEX Female		6. COLOR OR RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 6, 1887		9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE J. Karl Palmer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS J. Karl Palmer 5400 Rosa Ave.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Polycystic Kidneys - ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Birth? DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremic Coma				INTERVAL BETWEEN ONSET AND DEATH 3 yrs -  36 hrs		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Same as above				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 75-71 (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR				
22. I hereby certify that I attended the deceased from 3/11, 1950, to 4/5, 1950; that I last saw the deceased alive on 4/4, 1950, and that death occurred at 1:40A m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Cleveland H. Shults M.D.				23b. ADDRESS 2022 N. 4th St. Louis Mo		23c. DATE SIGNED 4/5/50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		24b. DATE Apr. 8, 1950		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Mausoleum		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		
DATE REC'D BY LOCAL REG. APR 6 1950		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.				

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

**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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Richard W. Stovissand*

Signed.....

Student Embalmer

Licensed Embalmer No..... *4007*

P. O. Address.....

**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.**