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FILED DEC 12 1950

THE DIVISION OF HEALTH - MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **36146**

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **311**

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) Columbia	c. LENGTH OF STAY (in this place) 1 da	c. CITY (If outside corporate limits, write RURAL and give township) Sturgeon 0100	
d. FULL NAME OF HOSPITAL OR INSTITUTION Boone Co. Hospital		d. STREET ADDRESS (If rural, give location) No street address	

3. NAME OF DECEASED (Type or Print) SAMUEL PALMER	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Nov. 25th 1950
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH about 1875	9. AGE (In years last birthday) (Months) (Days) about 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Matilda Palmer
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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 Charles Palmer	ADDRESS Kansas City Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 1 day several years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetic coma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) diabetes mellitis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		260X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov 24, 1950**, to **Nov 25, 1950**, that I last saw the deceased alive on **Nov 25, 1950**, and that death occurred at **7 p** m., from the causes and on the date stated above.

23a. SIGNATURE Dr. Roy J. Miller M.D.	(Degree or title)	23b. ADDRESS Columbia Mo.	23c. DATE SIGNED 27 Nov. 50
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 11-27-1950	24c. NAME OF CEMETERY OR CREMATORY Sturgeon	24d. LOCATION (City, town, or county) (State) Sturgeon Mo.
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DATE REC'D BY LOCAL REG. Dec 5th 1950	REGISTRAR'S SIGNATURE Mrs R.E. Palmer	31	EMERALD DIRECTOR'S SIGNATURE David Parker	ADDRESS Columbia Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 12/11/50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 12/11/50

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 _____ ^{not}

working under my personal supervision.

Signed.....
Student Embalmer

Signed *Stuart P. Parker*
Student Embalmer No.....

Licensed Embalmer No. *2900*

P. O. Address *Columbia, N.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.