

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23536

BIRTH NO. REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3644 Registrar's No. 66

0540  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD—

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington	
d. FULL NAME OF HOSPITAL OR INSTITUTION Goodloe Rest Home		d. STREET ADDRESS (If rural, give location) 23rd & Franklin Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) c. (Last) Palpacuer			4. DATE OF DEATH (Month) (Day) (Year) June 9 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 5, 1877	9. AGE (In years last birthday) 77	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 1 YEAR Days 4	12. IF UNDER 1 YEAR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner	10b. KIND OF BUSINESS OR INDUSTRY employee	11. BIRTHPLACE (City and State or Foreign Country) France	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Not Known	13b. MOTHER'S MAIDEN NAME Not Known	14. NAME OF HUSBAND OR WIFE Not Known
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Julia Lierman, Lexington, 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 3 mos.  Years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cornea Decompensation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial asthma		Years	

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)	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 1957, to June 9, 1954, that I last saw the deceased alive on June 4, 1954, and that death occurred at 7:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. K. Essensrud Md.	23b. ADDRESS Hggsville Mo	23c. DATE SIGNED July 2 54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 11 1954	24c. NAME OF CEMETERY OR CREMATORY Wachpelah	24d. LOCATION (City, town, or county) (State) Lexington Missouri
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DATE REC'D BY LOCAL REG. 5-4-54	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
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*H. J. Keenan*

AUG 9 19

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *H. J. Keenan*

Licensed Embalmer No. *2983*

P. O. Address *Louisville, Missouri*

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.