

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028754
STATE FILE NUMBER

FILED SEP 8 1958 Registration District No. 118 Primary Registration District No. 4190 Registrar's No. 31

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Gasconade</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Belle</u> 0630 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wiegler Clinic</u> Length of stay in 1b <u>15 minutes</u> | | d. STREET ADDRESS (If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JEESHA - NANNETTE - PALMER</u> | | | 4. DATE OF DEATH Month Day Year <u>Aug 31 - 1958</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 1 - 1957</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Infant)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington - Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Glen M. Palmer</u> | | 14. MOTHER'S MAIDEN NAME <u>Ruby H. Cain</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Glen Palmer - Belle - Mo</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Anoxia</u> DUE TO (c) <u>Gastro Intestinal Hemorrhage</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>3 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>Streptococcal infection of G.I. tract</u> | | | 19. WAS AUTOPSY PERFORMED? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>578x</u> | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>Aug 31, 1958</u> to <u>Aug 31, 1958</u> and last saw her ^{her} alive on <u>Aug 31, 1958</u> Death occurred at <u>11:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Wm. Tedder M.D.</u> | | 22b. ADDRESS <u>Bland, Mo</u> | |
| | | 22c. DATE SIGNED <u>9-2-58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | |
| <u>Buried Sept 2 - 1958</u> | | <u>Sept 2 - 1958</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| <u>Dixon Cemetery</u> | | <u>Dixon - Missouri</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Spasmalis Funeral Service</u> | | 25. DATE RECD. BY LOCAL REG. <u>September 4, 1958</u> | |
| <u>Bland - Mo</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. Marvin Jappewer</u> | |

Health, Welfare Public Service
300 1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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.....
Signature of Student Embalmer

Signed.....
Charles S. Sasser

Licensed Embalmer No. 417

P. O. Address: Bland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.