

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002375  
STATE FILE NUMBER  
27

FILED JAN 26 1959 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 27

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sedalia</u>		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>Bothwell Hospital</u>		Length of stay in 1b <u>12 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>1302 So. Osage</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>IRA</u> Middle <u>PAUL</u> Last <u>PALMER</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10 1876</u>	9. AGE (In years) last birthday) <u>82</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>6</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Smithton Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Edgar Palmer</u>		13b. MOTHER'S MAIDEN NAME <u>Ida L. Westlake</u>		14. NAME OF HUSBAND OR WIFE <u>Dora Alice Palmer</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 Name <u>Herbert Reynolds</u> Address <u>1405 S. 1st</u>		
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>gangrene both feet &amp; legs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>General arterio sclerosis</u>					
DUE TO (c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4501</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>					
20d. INJURY OCCURRED WHILE AT <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 <u></u> STATE <u></u>	
21. I attended the deceased from <u>10-1-58</u> to <u>1-16-59</u> and last saw him alive on <u>1-16-59</u> Death occurred at <u>9:00 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. R. Boger MD</u> (Degree or title)			22b. ADDRESS <u>Sedalia Mo</u>		22c. DATE SIGNED <u>1-19-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem cem</u>		23d. LOCATION (City, town, or county) (State) <u>Pettis Co. Mo</u>
24. FUNERAL DIRECTOR <u>McLaughlin Bros</u> ADDRESS <u>Sedalia</u>			25. DATE RECD. BY LOCAL REG. <u>Jan 20-1959</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *H.P.M. Crary* .....  
Licensed Embalmer No. *3103* .....  
P. O. Address *Sedalia 1* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.