Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006278
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 178 Primary Registration District No. _____ Registrar's No. 16

1. PLACE OF DEATH
a. COUNTY: Lewis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): LaGrange — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): At Home — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: Lewis
c. CITY OR TOWN: LaGrange 0560 c — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): No street address — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Owney — Middle: Edwin — Last: Palmer Sr.

4. DATE OF DEATH: Month / Day / Year: January 15, 1959

5. SEX: Male c
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: February 14, 1873
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (City and state or country): Elsberry, Missouri., o
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13a. FATHER'S NAME: Daniel Palmer
13b. MOTHER'S MAIDEN NAME: Georgia Palmer
14. NAME OF HUSBAND OR WIFE: Minnie 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.: None
17. INFORMANT: Robert Palmer — Address: Quincy, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): _____
DUE TO (c): _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 332X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] c

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 7-21-56, to Jan 15-59 and last saw her/him alive on Jan-14-59
Death occurred at 2 A.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Hendis Y Davis MD
22b. ADDRESS: Canton Mo
22c. DATE SIGNED: Jan 15-59.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan. 17, 1959
23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
23d. LOCATION (City, town, or county) (State): LaGrange, Missouri.

24. FUNERAL DIRECTOR: Kenneth Bailey — ADDRESS: La Grange Mo.
25. DATE RECD. BY LOCAL REG.: 3-2-'59
26. REGISTRAR'S SIGNATURE: P. W. Jennings M.D. E-L

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 J. Kenneth Bailey

Licensed Embalmer No. 4248

P. O. Address La Grange, Mo

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.