

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

376-62-030255  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 376

FILED SEP 4 1962

VS 300  
Rev. 4/59

10168  
21030

3  
4 1  
5 2  
6  
7 1  
8 0  
9581.0  
10  
11  
12 - 0  
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>CAPE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>STODDARD</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CAPE GIRARDEAU</b>		Length of stay in 1b <b>Wk.</b>	c. CITY OR TOWN <b>BLOOMFIELD.</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. FRANCIS HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE # 1,</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ADA T. PALMER</b>			4. DATE OF DEATH Month Day Year <b>AUG. 27, 1962</b>
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-1887</b>
9. AGE (last birthday) <b>74</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	11. BIRTHPLACE (City and state or country) <b>Shelby Co., INDIANA</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>E. V. Tucker</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Lola Cates, Bloomfield, Missouri</b>		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) <b>Carbosis of liver</b> DUE TO (b) <b>Post Neeratic Type</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 <b>Jan 30, 1962</b> to <b>death</b> and last saw her/him alive on <b>26 Aug 62</b> Death occurred at <b>5:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <b>[Signature]</b>		22b. ADDRESS <b>Cape Girardeau, Mo.</b>	22c. DATE SIGNED <b>8-27-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Aug. 27th 62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WALKER CEMETERY</b>	23d. LOCATION (City, town, or county) <b>BLOOMFIELD, MISSOURI</b> (State)
24. FUNERAL DIRECTOR <b>CHILES UND. CO., BLOOMFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>8-29-1962</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

USE BLACK INK OR TYPEWRITER RIBBON

SEP 11 1962

**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 James C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.