

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

REGISTRATION DISTRICT NO. 141 PRIMARY REGISTRATION DISTRICT NO. 3025 REGISTRAR'S NO. 127 **63-085101**

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 127

VS 300
Rev. 4/59

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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 <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u> Length of stay in 1b <u>since boy</u>		c. CITY OR TOWN <u>West Plains</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>125 College</u>		d. STREET ADDRESS (If outside, give location) <u>125 College</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mont</u> Middle <u>Clifton</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> , Year <u>1963</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>2-18-1882</u>
9. AGE (last birthday) <u>81 yrs.</u>		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) <u>retired millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>David J. Palmer</u>		13b. MOTHER'S MAIDEN NAME <u>Angie Ogen</u>	
14. NAME OF HUSBAND OR WIFE <u>Rose Hawkins</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Mrs. Rose Palmer, West Plains, Mo.</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>Cardiac decompensation</u> DUE TO (b) <u>ASHD</u> DUE TO (c) <u>CAS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CVA - Ca of prostate</u>			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 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 _____ 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 _____ to _____ and last saw him alive on <u>8-6-63</u> Death occurred at <u>8:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John E. Wilson, M.D.</u>		22b. ADDRESS <u>West Plains, Mo.</u>	
22c. DATE SIGNED <u>9-3-63</u>		23. LOCATION (City, town, or county) (State) <u>West Plains, Mo.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Cremial</u>	23b. DATE <u>8-29-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Robertsons, West Plains, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-4-63</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

USE BLACK INK OR TYPEWRITER RIBBON

SEP 11 1963

Wilson

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. ~~3452~~ ^{8482X}
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed A. H. Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.