

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039389

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 87 Primary Registration District No. 4565 Registrar's No. 90

STATE FILE NUMBER

FILED OCT 16 1963

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Franklin</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sullivan</u>		Length of stay in 1b <u>3 Days</u>	c. CITY OR TOWN <u>Sullivan</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sullivan Comm. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.R. #2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dennis Etherige Palmer</u>			4. DATE OF DEATH Month Day Year <u>Oct. 4, 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>12/11/1963</u>
9. AGE (last birthday) <u>62</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Industry</u>	11. BIRTHPLACE (City and state or country) <u>Troy, Indiana</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Edward Palmer</u>	
13b. MOTHER'S MAIDEN NAME <u>Ollie Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Lucy Johnson</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>[REDACTED]</u>	17. INFORMANT Address <u>Lucy Palmer, Sullivan, 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>GASTROINTESTINAL HEMORRHAGE</u> DUE TO (b) <u>DUODENAL ULCER</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 HR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>UREMIA CARDIAC DECOMPENSATION</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 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 <u>1958</u> to <u>1963</u> and last saw him alive on <u>OCT 4-1963</u> Death occurred at <u>5:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert J. [Signature] M.D.</u> (Degree or title)		22b. ADDRESS <u>Sullivan, Mo.</u>	22c. DATE SIGNED <u>Oct 6-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/7/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stanton, Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Stanton, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>H.M. Eaton, Sullivan, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-6-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ 12-11-1900
 AMENDED DATE AMENDED 12/11/63
 INSTEAD OF DOCUMENT
 SHOULD READ 12-11-1900
 BY AFFIDAVIT OF

VS 300 Rev. 4/59
 10281
 20366
 3
 4 D
 5 1
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 11 1-D
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USE BLACK INK OR TYPEWRITER RIBBON

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 Harrison W. Eator

Licensed Embalmer No. 5066

P. O. Address Shelton, 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.