

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **792**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo., (No. 1828)**

Carr St.

File No. **40091**

Registered No. **12119**

St. Ward)

2. FULL NAME

Thomas Palmer

(a) Residence. No. **1828^{1/2} Carr St.** St. **25** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

11-25-1901

7. AGE

25

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. or min.

0

26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

10. NAME OF FATHER

Thomas Palmer

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

West Virginia

12. MAIDEN NAME OF MOTHER

Elizabeth Stovall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

West Virginia

14.

INFORMANT (Address)

**Nathaniel William
1828^{1/2} Carr St.**

15.

FILED

**DEC 23 1925
19
Mayb Starsoff**

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-21-26 19

17.

I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....,

that I last saw him alive on, 19....., and that death occurred, on the date stated above, at **4:30 a**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**gun shot wound of
1926
back**

CONTRIBUTORY (SECONDARY) **suicide**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

Did AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Thos Dyer**
12/23/26 (Address) **Dep Coroner**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Greenwood Cemetery

20. UNDERTAKER

A. L. Beal

DATE OF BURIAL

Dec. 23rd 1926

ADDRESS

2726 Lucas ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

