

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

Do not use this space.

12951

1. PLACE OF DEATH
 County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 7001 File No. 323
 City Springfield (No. 1922 in Missouri) Registered No. 323 St. Ward

2. FULL NAME Mary E. Palmer
 (a) Residence No. West W. Missouri 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1844

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 Unknown

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at Home
 (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) Tenn.

10. NAME OF FATHER Samuel Bernard

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER Nancy Jolly

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT (Address) Mrs. M. Cain
Springfield, Mo.

15. FILED 4/28 28 October 1928

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-28-1928

17. I HEREBY CERTIFY, That I attended deceased from 4-22-1928, to 4-27-1928, that I last saw her alive on 4-23-1928, and that death occurred, on the date stated above, at 8 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
16.9 (duration) yrs. mos. 6 da.

CONTRIBUTORY (SECONDARY) Similarity (duration) yrs. mos. da.

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) C. E. Zeller, M. D.
 (Address) Springfield Mo

*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 DATE OF BURIAL
Canther Valley cemetery April 29, 1928

20. UNDERTAKER (Address) W. H. H. H. Co., 424 E. 2nd St.
Springfield, Mo.

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.

REGISTRAR

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