

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

Do not use this space.

16303

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.
Registered No. **4342**
St. Ward)

2. FULL NAME

(a) Residence. No. **308 Clark** 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 **25** 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 **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 15 - 1869**

7. AGE Years **68** Months **7** Days **8** If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED **Merchant**
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Illinois**
(STATE OR COUNTRY)

10. NAME OF FATHER **Tom H Palmer**

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

12. MAIDEN NAME OF MOTHER **Mrs. Alva**

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

14. INFORMANT **City Hospital**
(Address)

15. **488 14 1929** **Max C. Stanley**
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 13 1929**

17. I HEREBY CERTIFY, That I attended deceased from **April 13 1929** to **April 13 1929** that I last saw him alive on **April 13, 1929** and that death occurred, on the date stated above, at **6:10 PM**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Syphilis of Spinal Cord
30 Tubercular Spondylitis
34 Chronic Myocarditis
73C (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **28** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

20. WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **clinical; mass**
(Signed) **Edward H. ... M. D.**
4/14 1929 (Address) **City Hospital**

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Moberly Mo** DATE OF BURIAL **Apr 16 1929**

20. UNDERTAKER **Mohamund & Co** ADDRESS **Moberly Mo**

Valme.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No.) St. Ward)

File No.....
Registered No. 4342

2. FULL NAME

Alfred Palmer
(a) Residence. No. St. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) s

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 5-1861

7. AGE YEARS MONTHS DAYS IN LESS than 1 day, hrs. or min.
68 x 7 8

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT.....
(Address).....

15. FILED 22 1929 May C Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13 1929

17. I HEREBY CERTIFY That I attended deceased from.....
19..... to....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY).....
(duration)..... yrs. mos. ds.

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)....., M. D.

, 19 (Address)

*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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-16303