OCT 29 1930

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

Do not use this space.

30228

1. PLACE OF DEATH
County: Jasper
Township:
City: Carterville (No. ..... St. ..... Ward)

Registration District No. 407
Primary Registration District No. 4241

File No.
Registered No.

2. FULL NAME: Mrs. Mary 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
~~HUSBAND OF~~ (OR) WIFE OF: J. A. Palmer

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 6 1845

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	10	5	

8. OCCUPATION OF DEASCED
(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): Johnson County
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: A. J. Thornton
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Va
12. MAIDEN NAME OF MOTHER: Milvina Thurl
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Va

14. INFORMANT: Edward Palmer
(Address): Webb City Mo.

15. FILED 9-12, 1930 C. L. Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 11, 1930

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to Sept 11, 1930, that I last saw her alive on Sept 11, 1930, and that death occurred, on the date stated above, at 3 45 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
131
162 Chronic Interstitial Nephritis (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. 3 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) L. Lafebre, M. D.
Sept 19 30. (Address) Sheldon 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
Park Cemetery	9/13 1930
20. UNDERTAKER	**ADDRESS**
Webb City Undertaking Co.	Webb City

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.