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

Do not use this space.

41618

**1. PLACE OF DEATH**

County ..... Registration District No. 7811

Township ..... Primary Registration District No. [illegible]

City ST. LOUIS MO. (No. DEACONESS HOSPITAL. St. ..... Ward)

File No. .....

Registered No. 29

**2. FULL NAME** SOPHRONIA P. PALMER.

(a) Residence. No. 5622 GATES AVE. St., 5 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. | WIDOW. |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/17/1870.

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 60 | 9 | 14 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work HOUSEMAID. 2 10 N

(b) General nature of industry, business, or establishment in which employed (or employer) MRS. JOHN HURSHFELD.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILL.

PARENTS

10. NAME OF FATHER WM. M. SHILEY.

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

12. MAIDEN NAME OF MOTHER SARAH JANE PALMER.

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

14. INFORMANT Mrs Nettie Ritter
(Address) 5355 Vernon

15. FILED JAN -2 1931, 19 Max C Starkey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/31/30

17. No Physician in attendance
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 2:08 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock + Injuries (Lobar Pneumonia Fractured Left Tibia and Fibula) struck by auto in St. Louis Mo. (duration) ..... yrs. ..... mos. ..... ds.
Deceased was a pedestrian

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner M.D.
, 19 (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 BETHANIA, CEMETERY.

DATE OF BURIAL 1/2/31 19

20. UNDERTAKER Provost Land Co

ADDRESS 9710 N. Grand

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.