

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

Do not use this space.

APR 25 1934
10 03 33

1. PLACE OF DEATH

County Rockport
Township
City Rockport (No. _____) St. _____ Ward _____

Registration District No. 19
Primary Registration District No. 4013

File No. 7678
Registered No. _____

2. FULL NAME

Pansy Ella Linn Palmer

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 3 - 1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
35 6 16

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Keeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atchison Co Mo

13. NAME Paisie Linn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atchison Co Mo

15. MAIDEN NAME Addie Burgess

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jessie

17. INFORMANT (ADDRESS) Rockport Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Highway DATE Mar 21 1934

19. UNDERTAKER (ADDRESS) Rockport Mo

20. FILED 3-21 1934 Mary Chamberlain Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 19 1934

I HEREBY CERTIFY That I attended deceased from Mar 14 to 19 34 to March 19 34 1934
I last saw him alive on Mar 19 34 1934 Death is said to have occurred on the date stated above, at 1:15 P.M.

The principal cause of death and related causes of importance were as follows:

Pneumonia Fever Date of onset 10

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1934

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) William P. Strickland, M. D.

(Address) Rockport Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

**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 Johnson Registration District No. 19
 Township Rockport Primary Registration District No. 4013
 City Rockport St. _____ Ward _____
 Registered No. _____
 2. FULL NAME Pansy Ella Liers 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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 19, 1934

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____.

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

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

Crebricercular fever Date of onset _____

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)

15. MAIDEN NAME

Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

Manner of injury _____
 Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____

19. UNDERTAKER (ADDRESS)

(Signed) _____, M. D.
 (Address) _____

20. FILED _____ 19 March 9, 1934
Mary G. Chamberlain
 Registrar.

SUPPLEMENTARY

