

DEPT. SEP 16 1938

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

Do not use this space.

1. PLACE OF DEATH

County Adair Registration District No. 4
Township Clinton Primary Registration District No. 5005
City Kirksville (No. R.R.) St. _____ Ward _____

File No. 28170
Registered No. 137

2. FULL NAME

Lucinda Lina Palmerton 4:30
(a) Residence, No. Kirksville, Mo. St. R.R. 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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-15-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
68 10 24

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

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) 1-9-37 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adair Co. Mo.13. NAME Samuel M. Crawford14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn15. MAIDEN NAME Ella Ashlock16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois17. INFORMANT D. J. Palmerton (ADDRESS) Kirksville R.F.D.18. BURIAL, CREMATION, OR REMOVAL PLACE Lafayette Cem. DATE 8-12-193819. UNDERTAKER Dee Riley Funeral Home (ADDRESS) Kirksville Mo.20. FILED Aug 9 1938 Spencer Freeman Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 9 193822. I HEREBY CERTIFY, That I attended deceased from Aug 9 1938, to Aug 9 1938I last saw h. e. l. alive on Aug 9 1938. Death is saidto have occurred on the date stated above, at 12:00 p. m.

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

Catachol Pneumonia Date of onset Aug 4
(Catachol)
(Bronchial Pneumonia)

Other contributory causes of importance: Paralysis of i. system with Paralysis of 18 Mo.

Name of operation _____ Date of _____
What test confirmed diagnosis? Physic 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 _____ 19 _____

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? no
If so, specify _____

(Signed) L. J. Conroy M. D.
(Address) Kirksville Mo.

10.12
US FTS

RECEIVED

District Health Officer No. 10

District File Number 10-38-45

Date Filed 9/14/38

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28170
Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
 (b) Township Benton Primary Registration District No. 5005 Registered No. 137
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lucinda Sina Palmerton

(a) Residence, No. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 10 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 9 1938

22. I HEREBY CERTIFY, That I attended deceased from , to , 19 .

I last saw h..... alive on , 19 . Death is said to have occurred on the date stated above, at m.

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

Cerebral Pneumonia
Cerebral Hemorrhage as
result of ear drain from
Wright as the patient was
deaf at time I first saw her
 Date of onset

Other contributory causes of importance:
Paralysis of Eighteen months

8261

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 , 19 .

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) L. J. Corney, M. D.
 (Address)

SUPPLEMENT

Local Registrar.

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

1938
S-28170