

REC'D MAR 9 1939

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

5858
Do not use this space.

1. PLACE OF DEATH
(a) County Boone Registration District No. 73
(b) Township _____ Primary Registration District No. 3006
(c) City Columbia (d) Street No. _____ Registered No. 18
(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 Shirley Ester Palmer
(a) Residence, No. 605 Locust St 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Baby
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 12, 1938
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. X 9 19
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. Baby
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) Boone Co Mo
13. NAME George W Palmer Jr
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co Mo
15. MAIDEN NAME Sara Wilhite
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co Mo
17. INFORMANT (ADDRESS) George W Palmer Jr 605 Locust St
18. BURIAL, CREMATION, OR REMOVAL PLACE Bethlehem DATE Feb 2 1939
19. FUNERAL DIRECTOR (ADDRESS) A. Wilcox
20. FILED 2/27 1939 Alfred Selby Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 19 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 31 1939 to Feb 1 1939
I last saw her alive on 5/25, 1939 Death is said to have occurred on the date stated above, at 4:15 A.M.
The principal cause of death and related causes of importance were as follows:
Pneumonia (non) ✓ Date of onset _____
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 _____, 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) A. Wilcox M. D.
(Address) Columbia Mo.

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.

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STATEMENT BY LICENSED EMBALMER

I, Lynnan H. Sprinkle Licensed Embalmer No. 4013

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Covington

L. E. _____

No. _____ or by _____ Registered Apprentice No. _____

working under my personal supervision.

Signed Lynnan H. Sprinkle

Licensed Embalmer No. 4013

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

THIS STATEMENT MUST BE PROBABLY CL. 41854
IN ORDER TO BE CORRECTLY RECORDED. YOUR SIGNATURE AT THE END

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

5858
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1. PLACE OF DEATH *Boone*
 (a) County *Boone* Registration District No. *73*
 (b) Township *Columbian* Primary Registration District No. *3006* Registered No. *18*
 (c) City *Columbian* (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 *Shirley Ester Palmer*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode (if no street address, write county or city))

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Baby*

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.
X 9 19

OCCUPATION
 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 _____

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED _____ 19 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2-1-39*

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

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

The principal cause of death and related causes of importance were as follows:
Pneumonia (Bronch) Date of onset _____

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 _____, 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) *G. A. Bradford*, M. D.
 (Address) *Columbian, Mo.*

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY THIS BOARD. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

