

REC'D MAR 9 1939

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

5867
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. _____ 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 James 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

3. SEX M. 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-2-1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 9 6

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

12. BIRTHPLACE (CITY OR TOWN) Boone Co (STATE OR COUNTRY) MO

FATHER
13. NAME Do not know

14. BIRTHPLACE (CITY OR TOWN) Do not know (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Kathrine Palmer

16. BIRTHPLACE (CITY OR TOWN) Do not know (STATE OR COUNTRY)

17. INFORMANT Katie Jones (ADDRESS) 3840 Miller Place Station

18. BURIAL, CREMATION, OR REMOVAL PLACE mt Celestial DATE 2-12 1939

19. FUNERAL DIRECTOR (NAME) A. G. Freeman (ADDRESS) Columbia MO

20. FILED 2/15/39 1939 Allie Selby Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-8 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-3-39, 1939, to 2-8-39, 1939.
I last saw him alive on 2-7-39, 1939. Death is said to have occurred on the date stated above, at 10:40 a.m.

The principal cause of death and related causes of importance were as follows:
Influenza 7 days
Lobar Pneumonia 6 days

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 _____, 1939
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. M. D.
(Address) 301 N. 5th 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

A. C. Freeman

, Registered Apprentice No. _____

working under my personal supervision.

Signed A. C. Freeman

Licensed Embalmer No. 2837

P. O. Address Columbia Md

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.)

If this body is not embalmed, above space should be left blank.