

DEC 18 1939

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

40352
Do not use this space.

1. PLACE OF DEATH
 (a) County Madison Registration District No. 55
 (b) Township Georgetown Primary Registration District No. 6262 Registered No. 1400
 (c) City Georgetown (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 Elizabeth 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 Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Walter Palmer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 4 1904

7. AGE YEARS MONTHS DAY If LESS than 1 day, _____ hr. or _____ min. 35 + 5 2 11

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

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) Saturday 25/39 11. Total time (years) spent in this occupation _____

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

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

15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Walter Palmer
Bison Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Purple Hill DATE Dec 3 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Recherber
Madison Mo

20. FILED Dec 8 1939 M. V. Munn Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 1 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 29 29 1939 to Dec 1 1939
 I last saw her alive on Dec 1 1939. Death is said to have occurred on the date stated above, at 9 a. m.
 The principal cause of death and related causes of importance were as follows:
Exsufflation of base of brain and throat. Date of onset _____

Other contributory causes of importance: no

Name of operation none Date of _____
 What test confirmed diagnosis? Clonus Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____ 1939
 Where did injury occur? home (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 suicide

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) B. B. Quinn M. D.
 (Address) Georgetown 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.

RECEIVED

District Health Officer No. 2,

District File Number 1239-453

Date Filed 12-18-

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.