

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.

Registration District No. 218

Primary Registration District No. 3015

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Cooper
 (b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
(Specify whether)
 In this community
 years, months or days

8. (a) PRINT FULL NAME Judy Cayon Palmer
 9. (b) If veteran, name war ✓
 8. (c) Social Security No. ✓

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 24 - 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day
 hr. _____ min. _____

9. Birthplace Boonville Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business _____

FATHER { 12. Name Stanley Palmer
 13. Birthplace Cooper Co. MO.
(City, town, or county) (State or foreign country)
 14. Maiden name Alida C. Schlitzhausser
 15. Birthplace Cooper Co. MO.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Stanley Palmer
 (b) Address Tipton Missouri

17. (a) burial (b) Date thereof 1-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wesley Chapel Cooper Co.

18. (a) Signature of funeral director James B. Richards
 (b) Address Tipton Mo.

19. (a) 1-26-40 (b) W. S. Sawyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
 year 1940 hour 1 minute 45 P. M.

21. I hereby certify that I attended the deceased from Jan - 24, 1940, to Jan - 25, 1940
 that I last saw her alive on 1 - 25, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
SubinternaL Tear of
Meninges with hemorrhage
 Due to _____
 Due to _____
 Other conditions 160 lb
(Include pregnancy within 3 months of death)

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

Major findings:
 Of operations _____
 Of autopsy NO

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (e) Means of injury
 23. Signature Hubert S. Wells (M. D. or other) M.D.
 Address Boonville Mo. Date signed 1/26/40

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RECEIVED
 District Health Officer No. 8,
 District File Number
 Date Filed

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.