

No. 2
-1-441
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 7 1941
MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

20952

State File No. _____

Registration District No. 397

Primary Registration District No. 1002

Registrar's No. 2482

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2723 Wabash /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 26 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED: 048

(a) State Missouri (b) County Jackson 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 2723 Wabash 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lena A. Palmer

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29th
year 1941 hour 5 minute 5 A.M.

4. Sex Female 5. Color or race White

6. (a) Name of husband or wife Frank P. Palmer

6. (b) Age of husband or wife if alive _____ years
10, 1935
(Month) (Day) (Year)

6. (c) Single, widowed, married, divorced Widowed

21. I hereby certify that I attended the deceased from 6/28/41 to 6/29/41, 19____ to 19____;
that I last saw him alive on 6/29/41, 19____;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>4</u>	<u>19</u>	hr. _____ min. _____

Immediate cause of death: Profuse Meltina
Proctitis Anus.

Due to Amputation gangrene of right foot.

Due to _____ 61

Other conditions _____ 61
(Include pregnancy within 3 months of death)

9. Birthplace Scranton Pennsylvania
(City, town, or county) (State or foreign country)

10. Usual occupation House wife
At Home

11. Industry or business _____

12. Name William Scott Coy

13. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name Harriet Naoma

15. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy Chromal findings

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

16. (a) Informant Mrs. Ruth A. Schorn

(b) Address 2723 Wabash St

17. (a) burial (b) Date thereof 7/1/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director R. V. Lindsey & Sons

(b) Address 3311 Broadway
6/30/41

19. (a) _____ (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other) 6/29
Address [Signature] Date signed 1941

*Dr. C. R. Smith
A. J. Mays*

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..... *Leon W. Stewart*
Licensed Embalmer No. *4177*
P. O. Address..... *Kansas City, Mo*

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, fact should be so stated above.