

0.2
15.40
7.38

Registration District No. 72

Primary Registration District No. 4041

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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

3. (a) PRINT FULL NAME ELIZA JANE - PALMER

3. (b) If veteran, name war - 3. (c) Social Security No. _____

4. Sex 1 7 5. Color or race W 6. (a) Single, widowed, married, divorced 3 widowed
6. (b) Name of husband or wife Jesse Roberts 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2 1 1872
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 17 If less than one day hr. _____ min. _____

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

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER
12. Name Jesse Roberts
13. Birthplace Boone Co Mo. (City, town, or county) (State or foreign country)
14. Maiden name Margaret Ellen Jones
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Harry Bennett

(b) Address 5009 Chestnut Kansas City Mo

17. (a) Buried (b) Date thereof 6-30-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia Cemetery

18. (a) Signature of funeral director J. M. ...

(b) Address Centralia Mo
19. (a) 7-19-41 (b) F. J. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone
(c) City or town Centralia
(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 June day 18
year 1941 hour 11 minutes 30 A.M.

21. I hereby certify that I attended the deceased from June - 1941
_____, 19____, to _____, 19____;

that I last saw her alive on June 18, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of RT femur 4 in above knee and shock

Due to followed by broncho pneumonia
Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence 6/18
(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 W. S. White, M.D. (M. D. or other) _____
Address Centralia Mo Date signed June 19

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

10
1
0

D

Duration

49

1458
99

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.

Signature *[Handwritten Signature]*

Licensed Embalmer No. *2589*

P. O. Address *[Handwritten 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21094

Registration District No. 72

Primary Registration District No. 4041

Registrar's 'No. _____

1. PLACE OF DEATH:

(a) County Boone

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Eliza Jane Palmer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 69 Months 4 Days 17 If less than one day _____ min.

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18 year 1941 hour _____ minute _____ M.

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

Immediate cause of death Fracture of femur
Spinal

Due to fall
followed by Bronchitis

Due to Pneumonia

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

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) By fall

(b) Date of occurrence May 24-41

(c) Where did injury occur? Centralia Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In her room

While at work? No (Specify type of place) (e) Means of injury 4 in above knee

23. Signature W. G. White (M. D. or other) _____

Address Centralia Date signed Aug 12 41

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

