

FILED OCT 10 1942

State File No. ....

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 289

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fulton  
(c) Name of hospital or institution:  
300 West Fifth Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community 40 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Callaway  
(c) City or town Fulton  
(d) Street No. 300 West Fifth Street  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country..... 0

3. (a) PRINT FULL NAME ALDEN B. PALMER  
(b) If veteran, name war No (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 2 year 1942 hour 7 minute .....  
21. I hereby certify that I attended the deceased from July 25/42 to Sept 2 1942  
that I last saw alive on April 1 1942  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cardiac Insufficiency

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lela Wills-Palmer 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased Sept. 23 1866  
(Month) (Day) (Year)

Due to Arterio-sclerosis ?  
Due to nephritis ?  
Other conditions (include pregnancy within 3 months of death)  
Major findings: none  
Of operations none  
Of autopsy none

8. AGE: Years Months Days If less than one day  
75 11 9 hr. min.

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

10. Usual occupation Retired Weighmaster

11. Industry or business Fulton City Scales

MOTHER FATHER { 12. Name John C. Palmer  
13. Birthplace Calif.  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant (b) Address 300 W. Fifth, Fulton, Mo.

17. (a) Burial (b) Date thereof 9/4/42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Hillcrest Cemetery

18. (a) Signature of funeral director Les S. Wallace  
(b) Address Fulton, Missouri

19. (a) 9-4-42 (b) Joan Moravichoff  
(Date received local registrar) (Registrar's signature)

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.....  
(c) Where did injury occur?.....  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? Yes (Specify type of place) (e) Means of injury.....  
23. Signature Les S. Wallace (M. D. or other).....  
Address Fulton Mo Date signed 9-4-42

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

14  
1  
2

**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.....

working under my personal supervision.

*James R. Cady*

Registered Apprentice No. 329

Signed.....

*Albert E. White*

Licensed Embalmer No. 4168

P. O. Address Fulton, 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.**

STANDARD CERTIFICATE OF DEATH

State File No. 29971

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 289

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton  
(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  
In this community \_\_\_\_\_  
years, months or days)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Alden B Palmer

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 23  
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 0 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I first saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac insufficiency Duration P

Due to arterio sclerosis ?

Due to Nephritis chronic ?  
cause undetermined

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 \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature R. H. Hall (M. D. or other)

Address Fulton Mo Date signed 10/21/42

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

SUPPLEMENTARY

