

Registration District No. **360**

Primary Registration District No. **3076**

Registrar's No. **106**

1. PLACE OF DEATH:

(a) County **VERNON**

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

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

(d) Length of stay: In hospital or institution **4 DAYS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **RAY**

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

(d) Street No. **R 2** (If rural, give location)

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

3. (a) PRINT FULL NAME **JOSEPH PALMER**

3. (b) If veteran, name war _____

3. (c) Social Security No. **none**

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **9**

6. (b) Name of husband or wife **MARTH J PALMER**

6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **JULY 27 1878**
(Month) (Day) (Year)

8. AGE: Years **65** Months **3** Days **1** If less than one day hr. min.

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

10. Usual occupation **FARMER**

11. Industry or business _____

12. Name **HENRY C PALMER**

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

14. Maiden name **SUSAN J GRANTHAM**

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

16. (a) Informant **Martha J Palmer**

(b) Address **Richmond, Mo R 2**

17. (a) **BURIAL** (b) Date thereof **10-30-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BENTON GREEN (Cem)**

18. (a) Signature of funeral director **Swinn Siders**

(b) Address **El Dorado Springs, Mo**

19. (a) **11-2-43** (b) **Aazel B. Bewick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **28**
year **1943** hour **2** minute **PM**

21. I hereby certify that I attended the deceased from **OCT. 25 1943** to **OCT. 28 1943**
that I last saw him alive on **OCT. 28 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute spreading peritonitis 5 da**
Due to **Probably due to ex-**
cision from infected
gall bladder
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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)
_____ (Means of injury)

23. Signature **[Signature]** (M. D. or other) _____
Address **Merado, Mo** Date signed **10-29-43**

Duration **5 da**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

DR. ... Officer No. 7,

Case No. 10-43-1224

Date Recd. 11-9-43

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 [Signature]

Licensed Embalmer No. 2034

P. O. Address Edwards St. No.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *2201.*

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Vernon*
(b) City or town *Meranda*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution *4 da* (Specify whether

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

3. (a) PRINT FULL NAME *Joseph 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 *unk*

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

7. Birth date of deceased *July 27-1914*
(Month) (Day) (Year)

8. AGE: Years *65* Months *3* Days _____ 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *11-2-43* (Date received local registrar) (b) *Hazel B. Burch* (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 *Oct* day *27* year *1943* hour _____ minute _____ M.

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

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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

36032