

FILED JUL 26 1944

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(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 10 Hours
(Specify whether years, months or days)
In this community 16 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1816 Ohio
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Samuel Raymond Palmer

3. (b) If veteran, name war No 3. (c) Social Security No. 493-05-3452

4. Sex Male 5. Color or face White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna May 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Sep 9 1888
(Month) (Day) (Year)

8. AGE: Years 60 Months 10 Days 6 If less than one day hr. min.

9. Birthplace East Lynn Ill. Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Retired

12. Name Samuel Palmer

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

14. Maiden name Elizabeth McKee

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

16. (a) Informant Anna May Palmer

(b) Address 1816 Ohio Ave.

17. (a) Motor (b) Date thereof 7 / 17 / 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clay City Illinois

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301, Lafayette Ave.

19. (a) 1816 Ohio (b) J. F. Budeck
(Date of death) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 15
1944 year hour 7 minute 15 A.M.

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

Immediate cause of death. Cerebral Apoplexy

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 Thomas F. Callahan (M. D. or other)

Address Deputy Coroner Date signed 7/15/44

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

6349

6349

Fe 4 6 87

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 L.P. Crooken

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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.