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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26946

State File No. 3494

Registration District No. 147 Primary Registration District No. 1002 Registrar's No.

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: St. Mary's Hosp. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days (Specify whether
In this community 23 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 1546 East 49th St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William K. Palmer

3. (b) If veteran, name war No

3. (c) Social Security No. 486-03-8330.

4. Sex Male O

5. Color or race White

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

6. (b) Name of husband or wife Josephine Palmer

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Sept. 5, 1889
(Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 21 If less than one day hr. min.

9. Birthplace Clyde, Kas. / —
(City, town, or county) (State or foreign country)

10. Usual occupation Bill Foster

11. Industry or business Merritt Outdoor Advertising Co.

FATHER
12. Name Lorenzo Palmer
13. Birthplace New York /
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ellen Sharkey
15. Birthplace Cincinnatti, Ohio /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Josephine Palmer
(b) Address 1546 East 49th St.

17. (a) Removal (Auto) (b) Date thereof Aug. 28, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Paola, Kas.

18. (a) Signature of funeral director Thos. E. Quirk Funeral Home
(b) Address 4316 Troost Ave.

19. (a) 8-27-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26th
year 1944 hour 12.20 P.M. minute M.

21. I hereby certify that I attended the deceased from Aug 10, 1944, to Aug 26, 1944
that I last saw him alive on Aug 26, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach

Due to —

Due to —

46K

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation

Of autopsy Carcinoma of Stomach with metastasis

Duration

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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature P. H. Owens (M. D. or other)
Address 1034 Realty K Cms Date signed 8/27/44

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(Licensed Embalmer's Statement on Reverse Side)

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 Thomas E. Funk

Licensed Embalmer No. 3775

P. O. Address K.C. 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.