

FILED DEC 18, 1944

Registration District No. 187

Primary Registration District No. 5-639

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Rura - Washington Miss  
(c) Name of hospital or institution:  
1 1/2 East @dessa Mo.  
(d) Length of stay: In hospital or institution  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54  
(c) City or town Rura - Washington Miss  
(d) Street No. 1 1/2 mi. East @dessa  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Joe Arch Pallette

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Irene Pallette 6. (c) Age of husband or wife if alive 85 years  
7. Birth date of deceased Dec. 27 1857

8. AGE: Years 86 Months 10 Days 10 If less than one day hr. min.

9. Birthplace Mead - Oak Grove Mo. U.S.A.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer - Retired

11. Industry or business

MOTHER FATHER { 12. Name James Pallette  
13. Birthplace Unknown Unknown  
14. Maiden name Margaret Ann Dickerson  
15. Birthplace Unknown Unknown

16. (a) Informant Cecil Pallette  
(b) Address @dessa Mo.  
17. (a) Burial (b) Date thereof 11 9 1944  
(c) Place: burial or cremation Oak Grove - Mo.

18. (a) Signature of funeral director  
(b) Address @dessa Mo.

19. (a) Nov-28-44 (b) Mrs W. Baker  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7 year 1944 hour 10 minute M.

21. I hereby certify that I attended the deceased from Nov 7 1944 to Nov 7 1944  
that I last saw him alive on Nov 7 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Unknown Duration

Due to Unknown  
Due to Unknown  
Other conditions (Include pregnancy within 3 months of death)

ADDITIONAL

Major findings: SUPPLEMENTARY INFORMATION REQUESTED  
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?  
(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 R. D. Baker  
Address @dessa Mo. Date signed 11/9/44

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 12-7-47

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 *Horace Blunice*

Licensed Embalmer No. *2758*

P. O. Address *Delissa, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Sarasota  
(b) City or town Rural - Washington  
(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

3. (a) PRINT FULL NAME

Joe Rich Pallette

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 Dec 27 (Month) (Day) (Year)

8. AGE: Years 86 Months 10 Days \_\_\_\_\_ (if less than one day) \_\_\_\_\_ min.

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

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)  
(Burial, cremation, or removal)

(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 Jan Day 28 Year 1946 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 \_\_\_\_\_

Due to Chronic nephritis  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy 131

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? \_\_\_\_\_

23. Signature H. Schaefer (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 12/18/46

**SUPPLEMENTARY**

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

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

MOTHER FATHER

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