

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2816
Do not use this space.

FILED FEB 6 1945

1. PLACE OF DEATH

(a) County Macon Registration District No. 203
 (b) Township Jackson Primary Registration District No. 5735 Registered No. _____
 (c) City Atlanta Mo (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred whole life (If death occurred in Hospital or Institution, write its name instead of street and number) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Myrtle Palmer

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. J. S. Palmer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 30 1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>66</u>	<u>3</u>	<u>9</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. house wife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Mo

FATHER

13. NAME John Roberts

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER

15. MAIDEN NAME Mahaley Hardgrave

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Mrs. J. S. Palmer Atlanta Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE W. L. Carter DATE 1-11-1945

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Funerary Atlanta Mo

20. FILED Jan 20 1945 Mrs. A. L. Campbell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 8 - 1945

22. I HEREBY CERTIFY That I attended deceased from Jan. 4 1945 to Jan. 8 1945

I last saw her alive on Jan. 8 1945 Death is said to have occurred on the date stated above, at 1:30 p.m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset 1/4/45

Other contributory causes of importance: Hypertention and arterio-sclerosis. 1935

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Palmer Gillis D. O. M. D.
 (Address) La Plata, Mo.

RECEIVED

District Health Officer No. 10

District File Number 2-45-218

Date Filed FEB 5 1945

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.