

No. 2
1-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3587
State File No. _____
Registrar's No. 195

Registration District No. 2-38 Primary Registration District No. 4355

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town New Madrid
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
In this community 6 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME NANNIE PALMER
3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex 3 FEMALE 5. Color or race COLORED 6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife Paul Palmer 6. (c) Age of husband or wife if alive 4 years
7. Birth date of deceased Oct - 20 - 1914
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 4 11 hr. min.

9. Birthplace Homes Co. Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

MOTHER FATHER

12. Name Mrs. Halliday
13. Birthplace Madison Co. Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Rosie Palmer
15. Birthplace Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Rosie Halliday
(b) Address New Madrid, Mo.

17. (a) Removed (b) Date thereof (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation Richardson, Miss.

18. (a) Signature of funeral director Richardson and Co.
(b) Address New Madrid, Mo.

19. (a) 3-6-47 (b) Nelva Louise Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town New Madrid 720
(If outside city or town limits, write "RURAL") 3
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 1
year 1947 hour 10:00 minute 21 A.M.
21. I hereby certify that I attended the deceased from Feb 1 1947 to March 1 1947
that I last saw her alive on Feb 25 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
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 INFORMATION REQUESTED
(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 0
23. Signature B. Chandler (M. D. or other) MD
Address New Madrid Date signed 3/5/47

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

216

RECEIVED
District Health Office No. 25
District File Number 347-325
Date Filed 3-7-47

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..... *I. G. Collins*
Licensed Embalmer No. *4346*
P. O. Address *New Madison*

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.

Registration District No. 238

Primary Registration District No. 4255

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town New Madrid
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Nannet Palmer

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

4. Sex F 5. Color B 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 20 (Month) 1947 (Day) 1947 (Year)

8. AGE: Years 32 Months _____ Days _____ (unless than one day) _____ hr. _____ 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) _____ (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 March, year 1947, hour _____, minute _____, 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 _____

Broncho Pneumonia Duration _____

Due to _____

Due to _____

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

Major findings: 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? _____ (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

S-5577