

No. 2
-12-45
5-17-39
I X47070

FILED JUN 23 1947

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
State Hospital #2.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 62 days
(Specify whether)

In this community Life
(years, months or days)

3. (a) PRINT FULL NAME Oscar Francis Palmer

3. (b) If veteran, name war none

3. (c) Social Security No. 491-24-9992

4. Sex Male 5. Color or race White

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

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

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased April 7 1886
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>61</u> | <u>2</u> | <u>3</u> | hr. min. |

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Attendant

11. Industry or business State Hospital #2.

12. Name James W. Palmer

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

14. Maiden name Maggie Sears

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

16. (a) Informant Mrs. Cecile Palmer

(b) Address St. Joseph, Mo.

17. (a) burial (b) Date thereof 6/12/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Heaton Bowman

(b) Address St. Joseph, Mo.

19. (a) 6-16-47 (b) G. L. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2702 Seneca St.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1947 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from 13-5-47 1947 to 6-10-47 1947
that I last saw him alive on 6-10-47 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia hypostatic

Due to Cardio-Vascular - Renal Disease

Due to _____

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

Major findings: Of operations _____

Of autopsy (1) (3) (A)

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 0

23. Signature J. C. Sauer (M. D. 09230)

Address 202 W. 1st St. St. Joseph, Mo. Date signed 6-11-47

Duration

8 wks.

7 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

AUG 29 1948

MAY 25 1948

Form 1

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..... Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 3196 10th St Joseph, 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.