

FILED JAN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42429

BIRTH NO. _____ REG. DIST. NO. 88 PRIMARY REG. DIST. NO. 4151 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY CRAWFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CRAWFORD	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN STEELVILLE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN STEELVILLE	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) NORMA b. (Middle) LEE c. (Last) PALMER			4. DATE OF DEATH (Month) (Day) (Year) 12-10-1948		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 6-3-1919	9. AGE (In years last birthday) 29	10. UNDER 1 YEAR Months 6 Days 7	11. UNDER 2 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) CRAWFORD Co., MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME GILBERT PALMER	13b. MOTHER'S MAIDEN NAME BLANCHE KEY	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ALLEEN PALMER-STEELVILLE, MO.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. 337	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 month
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Influenza		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 2/10			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Steelville Crawford Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **Nov. 15, 1948**, to **Dec 10, 1948**, that I last saw the deceased alive on **Dec 10, 1948**, and that death occurred at **12:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William H. Riley DO	23b. ADDRESS Steelville Mo.	23c. DATE SIGNED 12/23/48
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-11-1948	24c. NAME OF CEMETERY OR CREMATORY STEELVILLE CEMETERY	24d. LOCATION (City, town, or county) (State) STEELVILLE, MO.
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DATE REC'D BY LOCAL REG. 1-8-49	REGISTRAR'S SIGNATURE [Signature] 76	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS STEELVILLE, MO.
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(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED 1-12-49
District Health Officer No. 5
District File Number 14935
Date Filed 1-13-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Thomas S. Herbert

Licensed Embalmer No. 4332

P. O. Address *Steelville, 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.