

FILED AUG 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22512

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 30 PRIMARY REG. DIST. NO. 4038 Registrar's No. 30

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Benton</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Hickory</u> | |
| b. CITY OR TOWN <u>Warsaw</u> | | c. CITY OR TOWN <u>Crossttimbers</u> | |
| c. LENGTH OF STAY (in this place) <u>3 years</u> | | d. STREET ADDRESS (If rural, give location) _____ | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lakeside Rest Home</u> | | | |

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|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>DAN</u> b. (Middle) <u>WICKERSON</u> c. (Last) <u>PALMER</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 1 1949</u> | | |
|--|--|--|---|--|--|

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|--------------------|-------------------------------|---|--------------------------------------|---|--|---|
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Nov 24, 1860</u> | 9. AGE (In years last birthday) <u>88</u> | IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> | IF UNDER 1 WEEK Hours _____ Min. _____ |
|--------------------|-------------------------------|---|--------------------------------------|---|--|---|

| | | | |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>"chick tractor doctor"</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (State or foreign country) <u>Logan, Iowa</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
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|--|---|--|
| 13a. FATHER'S NAME <u>William Palmer</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary E. Palmer</u> | 14. NAME OF HUSBAND OR WIFE <u>Mary Palmer</u> |
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| | | |
|--|-----------------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ | 16. SOCIAL SECURITY NO. <u>no</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Lred Palmer</u> ADDRESS <u>K.C. Mo</u> |
|--|-----------------------------------|---|

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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, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> |
| | ANTECEDENT CAUSES Morbid 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. | | |

| | | |
|------------------------------------|--|--|
| 19a. DATE OF OPERATION <u>NONE</u> | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------------|--|--|

| | | |
|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>WARSAW Benton MO</u> |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u> | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>✓</u> |

22. I hereby certify that I attended the deceased from May 10, 1949 to Aug. 1, 1949, that I last saw the deceased alive on Aug. 1, 1949, and that death occurred at 11:30 pm from the causes and on the date stated above.

| | | |
|--|---------------------------------|--------------------------------|
| 23a. SIGNATURE <u>Ever Valley DO</u> (Degree or title) | 23b. ADDRESS <u>Warsaw, Mo.</u> | 23c. DATE SIGNED <u>8/2/49</u> |
|--|---------------------------------|--------------------------------|

| | | | |
|---|--|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Aug 4, 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Independence Grove</u> | 24d. LOCATION (City, town, or county) (State) <u>Mo</u> |
| DATE REC'D BY LOCAL REG. <u>Aug 3 1949</u> | REGISTRAR'S SIGNATURE <u>Jas. A. Logan</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Reser</u> | ADDRESS _____ |

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

RECEIVED

District Health Officer No. 7

District File Number 7-49-95

Date Filed 8-8-29

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.

Signed _____

John F. Reser

Licensed Embalmer No. 4098

P. O. Address Warsaw

Signed _____
Student Embalmer

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.