

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32674

BIRTH NO. _____ REG. DIST. NO. 225 PRIMARY REG. DIST. NO. 4480 Registrar's No. 341

1. PLACE OF DEATH a. COUNTY <i>Schuyler</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Marion IA.</i> b. COUNTY <i>Linn</i>	
b. CITY (If outside corporate limits, write RURAL and give township) <i>Greentop Mo.</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>Iowa</i>	
c. LENGTH OF STAY (In this place) <i>3 da.</i>		d. STREET ADDRESS (If rural, give location) <i>Rural 2</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Van Osdol Hospital & Clinic</i>			

3. NAME OF DECEASED (Type or Print)	a. (First) <i>Wilma</i>	b. (Middle) <i>Eathel</i>	c. (Last) <i>Palmer</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>Sept. 28, 1949</i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec. 21, 1908</i>	9. AGE (In years last birthday) <i>40</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Linn Co., Iowa</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>William H. Mills</i>	13b. MOTHER'S MAIDEN NAME <i>Anna C. Summers</i>	14. NAME OF HUSBAND OR WIFE <i>Glen Owen Palmer</i>
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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). <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Glen O. Palmer, Marion, Iowa</i>	ADDRESS <i>Marion, Iowa</i>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Contusion of Brain &</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Contusions to Chest & Abdomen</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) <i>Y/</i>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>Accident</i>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <i>4124 W. 63 - near University</i>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Marion IA</i>
21d. TIME OF INJURY (Month) (Day) (Year) <i>9 26 49 7:45</i>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>in a fall from stairs</i>

22. I hereby certify that I attended the deceased from *9-26*, 19*49*, to *9-28*, 19*49*, that I last saw the deceased alive on *9-28*, 19*49* and that death occurred at *2:10 P. m.*, from the causes and on the date stated above.

23a. SIGNATURE <i>W. O. Osdol</i>	(Degree or title) <i>D.O.</i>	23b. ADDRESS <i>Van Osdol Hospital - Greentop Mo.</i>	23c. DATE SIGNED <i>9-28-49</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	24b. DATE <i>9/28/49</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Central City</i>	24d. LOCATION (City, town, or county) (State) <i>Marion, Iowa</i>
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DATE REC'D BY LOCAL REG. <i>Sept. 30, 49</i>	REGISTRAR'S SIGNATURE <i>Wm. R. J. Greer</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Paul M. Tracy</i>	ADDRESS <i>Kirkville, Mo.</i>
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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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OCT 5 1949
RECEIVED
District Health Officer No. 10
District File Number 10-49-172
Date Filed OCT 5 1949

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.....

.....
working under my personal supervision.

..... Student Embalmer No.....

Signed Ray H. Mercer

Signed.....
Student Embalmer

Licensed Embalmer No. 4432

P. O. Address Kirksville, 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.