

FILED MAY 27 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18527  
1400

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		a. STATE <u>Mo</u> b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis 2259</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>1432 No 13<sup>th</sup> St</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ELLA</u>	b. (Middle)	c. (Last) <u>PALMER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 12, 1950</u>
----------------------------------------	------------------------	-------------	-------------------------	-----------------------------------------------------------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Wid</u>	8. DATE OF BIRTH <u>May 1 - 1892</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months Days	IF UNDER 18 YRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>me</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Miss</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Andrew Daise</u>	13b. MOTHER'S MAIDEN NAME <u>Gemine Cain</u>	14. NAME OF HUSBAND OR WIFE <u>Harold</u>
-------------------------------------------	-------------------------------------------------	----------------------------------------------

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.	17. INFORMANT'S SIGNATURE OR NAME <u>State Hospital Records</u>	ADDRESS <u>ST. Louis Mo</u>
----------------------------------------------------------------------------------------------------------	-------------------------	--------------------------------------------------------------------	--------------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--------------------------------------------------------------------------

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
------------------------------------------	-----------------------------------------------------------------------------------------	-------------------------------------------------

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? <u>H201</u>
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	-------------------------------------------

22. I hereby certify that I attended the deceased from Jan. 1, 1945, to May 12, 1950, that I last saw the deceased alive on May 12, 1950, and that death occurred at 2:10p m., from the causes and on the date stated above.

23a. SIGNATURE <u>Jack R. Delman</u>	(Degree or title)	23b. ADDRESS <u>5400 Arsenal St.</u>	23c. DATE SIGNED <u>5/13/50</u>
-----------------------------------------	-------------------	-----------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>MAY 17 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State)
-------------------------------------------	---------------------------------	---------------------------------------------------------------	-----------------------------------------------

DATE REC'D BY LOCAL REG. <u>MAY 1 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Luster</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Kowland Mortuary Service Inc.</u>	ADDRESS
-----------------------------------------------	----------------------------------------------	--------------------------------------------------------------------------	---------

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

---

---

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.....  
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.