

FILED FEB 27 1951
0143

THE DIVISION OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

State File No. 4010

BIRTH NO. 2 REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 2008 Registrar's No. 35

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

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) PALMER c. (Last) PALMER			4. DATE OF DEATH (Month) (Day) (Year) Feb 12 1951		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH Oct 1866	9. AGE (In years less birthday) 84	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real estate		10b. KIND OF BUSINESS OR INDUSTRY Real estate	11. BIRTHPLACE (State or foreign country) dk 7		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Palmer	13b. MOTHER'S MAIDEN NAME Rosy M Entyre	14. NAME OF HUSBAND OR WIFE dk
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) dk dk	16. SOCIAL SECURITY NO. dk	17. INFORMANT'S SIGNATURE OR NAME Mrs Rose Habre ADDRESS 1022 Sheridan St Lexington Mo
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 491X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ch. Pneumonia		
	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. Chr myocarditis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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 **2-8**, 1951, to **2-12** 1951, that I last saw the deceased alive on **2-12**, 1951, and that death occurred at **2:30** p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J C Caldwell DM L	23b. ADDRESS State Hos Fulton Mo	23c. DATE SIGNED 2-12-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb 14 - 1951	24c. NAME OF CEMETERY OR CREMATORY Methodist Cem	24d. LOCATION (City, town, or county) (State) Lexington Mo
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DATE REC'D BY LOCAL REG. Feb 12 - 1951	REGISTRAR'S SIGNATURE Maretha Lawrence	25. FUNERAL DIRECTOR'S SIGNATURE Wallace General Home ADDRESS Fulton Mo
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(Licensed Embalmers' Statement on Reverse Side)

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

File No. _____
DISTRICT HEALTH OFFICE No. 4

FEB 19 1951

RECEIVED

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 _____

Wm. C. Trebbe

working under my personal supervision.

Student Embalmer No. 413

Signed *William C. Trebbe*
Student Embalmer

Signed *Denzil C. Browning*

Licensed Embalmer No. 2724

P. O. Address *Fulton, 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.