

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9782**
Registrar's No. **77**

BIRTH **MAR 29 1954** REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058**

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis 4071	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. CITY OR TOWN Breckenridge Hills	
c. LENGTH OF STAY (in this place) 5 days		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		e. STREET ADDRESS (If rural, give location) 9718 St. Charles Road	

3. NAME OF DECEASED (Type or Print) a. (First) Roy	b. (Middle) Finkney	c. (Last) Palmer	4. DATE OF DEATH (Month) (Day) (Year) Mar. 19, 1954
--	----------------------------	-------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 12, 1893	9. AGE (In years last birthday) Months Days 61	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------------	---	----------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Implement Dealer	10b. KIND OF BUSINESS OR INDUSTRY Farm Machinery	11. BIRTHPLACE (City and State or Foreign Country) Pleasant Hill, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	--

13a. FATHER'S NAME Jeff Palmer	13b. MOTHER'S MAIDEN NAME Josephine Merrifield	14. NAME OF HUSBAND OR WIFE Mercedes M. Palmer
---------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mercedes M. Palmer	ADDRESS 9718 St. Charles Rd.
--	-------------------------------------	---	-------------------------------------

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) C.N.S. Les		3 mo
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia.		2 days	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 026X	20. AUTOPSY? YES <input checked="" 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?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **2-10-54** to **3-19-54**, that I last saw the deceased alive on **3-19-54**, and that death occurred at **4:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE R. J. Endice M.D. (Degree or title)	23b. ADDRESS St. Charles, Mo	23c. DATE SIGNED MARCH 20 1954
---	-------------------------------------	---------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-22-1954	24c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery	24d. LOCATION (City, town, or county) (State) PATTANVILLE, Mo.
--	----------------------------	--	---

DATE REC'D BY LOCAL REG. March 19 1954	REGISTRAR'S SIGNATURE Faunne Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE Edmunds Bros. Inc. ADDRESS 2504 WOODSEN RD-OVERLAND, Mo.
---	--	---

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

MAR 25

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.....
Signature of Student Embalmer

Signed *David C. Gibson*.....

Licensed Embalmer No. *343*.....

P. O. Address *Orlando*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.