

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 1959 / 38

59-028862

Registration District No. _____ Primary Registration District No. 8522 Registrar's No. 31

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Hickory</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Hickory</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Cross Timbers</u>	Length of stay in lb <u>8 years</u>	c. CITY OR TOWN <u>Cross Timbers</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Central Cross Timbers</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Charles</u>	Middle <u>E.</u>	Last <u>Palmer</u>	4. DATE OF DEATH	Month <u>Aug</u>	Day <u>24</u>	Year <u>1959</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-79</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u> Hours <u>0</u> Min.	IF UNDER 24 HR Hours <u>0</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Welder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (City, and state or country) <u>Climax, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Richard Palmer</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Bessie May 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) <u>Yes World War 2</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT <u>Charles J. Palmer - Grand Rapids, Mich</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)	<u>Myocardial Failure</u>	
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.	DUE TO (b) <u>Myocardial Weakness</u>	
	DUE TO (c) <u>Taking 5 kinds med. from vet shop</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Coroner Case and last saw her alive on _____
Death occurred at approximately 8 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J R Easton</u>	(Degree or title) <u>Coroner</u>	22b. ADDRESS <u>Waukegan, Ill</u>	22c. DATE SIGNED <u>Aug 28 59</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-26-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cross Timbers Mo</u>	23d. LOCATION (City, town, or county) <u>Cross Timbers, Mo</u>
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24. FUNERAL DIRECTOR <u>Robert H. Murray - Waukegan, Ill</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Aug 24 1959</u>	26. REGISTRAR'S SIGNATURE <u>May Johnson</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 8 1930

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____

or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Chas Gilbert Wilkerson

Licensed Embalmer No. 4267

P. O. Address Wheatland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.