

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009354

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 508

FILED FEB 23 1962

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1507 S. Rock Hill Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER L. PALMER SR.</u>			4. DATE OF DEATH Month Day Year <u>February 9, 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1916</u>
9. AGE (last birthday) <u>45</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Calif. Chem. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Walter Palmer</u>	
13b. MOTHER'S MAIDEN NAME <u>Emma Blevins</u>		14. NAME OF HUSBAND OR WIFE <u>Haroldine M. Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W. W. #2</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>Haroldine Palmer</u>		Address <u>1507 S. Rock Hill</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe traumatic injury with crushed chest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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.) <u>Operator of vehicle involved in collision with truck</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>7:40 a.m. 2/9/62</u>		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.) <u>highway</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Louis Missouri</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>Coroner Clayton, Missouri</u>	
22c. DATE SIGNED <u>2/14/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 12, 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kirkwood, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser West 9450 Olive Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>2-12-62</u>	
		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

4002
240072

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4 0
5 1
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7 1
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9 X
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11 400
12 292-3
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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

William B. White

Licensed Embalmer No.

4291

P. O. Address

328 Liberty Highway

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.