

FILED JUL 25 1949  
#97912

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25169

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6066**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission!) a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1.</b>		d. STREET ADDRESS (If rural, give location) <b>12 - Parkview Hotel, 40 N. Kingshighway</b>	

3. NAME OF DECEASED (Type or Print) <b>CHARLES W. PALMER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 8th, 1949</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 23, 1871</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturer</b>		11. BIRTHPLACE (State or foreign country) <b>Eau Claire, Wisconsin</b>	
13a. FATHER'S NAME <b>Byron W. Palmer</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Abn. Dolles</b>		14. NAME OF HUSBAND OR WIFE <b>Margaret Palmer</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Lois Dennison, Washington D.C.</b>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES (b) <b>arteriosclerosis</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Hypertensive cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>10 + yrs.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>97</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4500</b>	

22. I hereby certify that I attended the deceased from **7/6/49**, 19**49**, to **7/8/49**, 19**49**, that I last saw the deceased alive on **7/8/49**, 19**49**, and that death occurred at **8:25 am**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Christiane Taylor M.D.</b>		23b. ADDRESS <b>1515 Lafayette Ave.</b>		23c. DATE SIGNED <b>7/8/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>7-11-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>California, Mo.</b>	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>JUL 11 1949</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	
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*Wm*

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 *Me*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Eaton B. Remelius*

Licensed Embalmer No. *4283*

P. O. Address *St. Louis, 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.