

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 301929

301929

Registrar's No. 7992

Registration District No. 1003

Primary Registration District No. _____

1. PLACE OF DEATH: 1003
 (a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Homer Phillips 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Since 8/26/39
 (Specify whether _____)
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis 27
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2108 Eugenia
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Sophia Turner 65 la
 (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced Separat
 6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan. 1, 1868
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 8 9 hr. _____ min.

9. Birthplace Mississippi
 (City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER { 12. Name Jim Berry
 13. Birthplace Virginia
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Charity Jordan
 15. Birthplace Virginia
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Doble Turner
 (b) Address 2108 Eugenia

17. (a) Father Dickson Date thereof 9-16-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation North Dixie

18. (a) Signature of funeral director L. Thomas
 (b) Address 2736 Madison

19. (a) SEP 16 1939 (b) _____
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10th
 year 1939 hour 8 minute 05 a. M.
 21. I hereby certify that I attended the deceased from Aug. 26, 1939
 _____, 19____, to Sept. 10, 1939, 19____;
 that I last saw her alive on Sept. 10, 1939, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis with hypertension Duration 10-12 yrs

Due to _____
 Due to _____
 Other conditions _____
 (Includes pregnancy within 3 months of death)

Major findings: MI
 Of operations _____
 Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. J. Lyman (M. D. 25255)
 Address 2601 N. Whittier Date signed 9/13/39

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.....

Harrison Eaton

Registered Apprentice No. *Y10*

working under my personal supervision.

*City license
180*

Signed

Raymond E. Gehlke

Licensed Embalmer No. *3985*

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, above space should be left blank.