

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.

JAN 12 1940 791

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **10504**

1. PLACE OF DEATH: **MOU3** /

(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: **Missouri Pacific Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 weeks**
(Specify whether _____)

In this community **life**
years, months or days

3. (a) PRINT FULL NAME **William F. Turner 656**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Dolly** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 4 1862**
(Month) (Day) (Year)

8. AGE: Years **77** Months **5** Days **3** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Fireman**

11. Industry or business **Railroad**

12. Name **not known**

13. Birthplace **not known**
(City, town, or county) (State or foreign country)

14. Maiden name **not known**

15. Birthplace **not known**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Robert Turner**

(b) Address **9208 Tudor**

17. (a) **Burial** (b) Date thereof **Dec. 9, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus**

18. (a) Signature of funeral director **John D. Ziegenhein**

(b) Address **7027 Gravois Ave**

19. **DEC 8 1939** (b) **J. D. Bridgman**
(Received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED: /

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis, M** **16**
(If outside city or town limits, write "RURAL")

(d) Street No. **3618 Hydraulic**
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **6**
year **1939** hour **11** minute **00 P.M.**

21. I hereby certify that I attended the deceased from **11-14**, 19**39**, to **12-6**, 19**39**
that I last saw him alive on **12-6**, 19**39**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chr. Myocarditis cerebral sclerosis**

Due to **Rt. hemiplegia**

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: **Cerebral sclerosis**

Duration

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? _____

23. Signature **Geo. W. Blankenship** (M.D. number) **MD.**
Address **1755 S. Grand** Date signed **12-23-39**
While at work? _____ (Specify type of place) (e) Means of injury _____

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.