

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27045

State File No.

6941

Registration District No. 19791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis  
 (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 G. Phillips  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 MOS. 27 days  
(Specify whether  
 In this community 19 years  
years, months or days)

3. (a) PRINT FULL NAME Dan Turner

3. (b) If veteran, name war No

3. (c) Special Security No. None

4. Sex male 5. Color or race Negro 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Julia Turner 6. (c) Age of husband or wife if alive 18 years  
 7. Birth date of deceased 4 (Month) 18 (Day) 1875 (Year)

8. AGE: Years 65 Months 3 Days 25 If less than one day hr.  min.

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

10. Usual occupation Librarian

11. Industry or business Pastor

MOTHER FATHER  
 12. Name Jal Turner  
 13. Birthplace Covington (City, town, or county) Texas (State or foreign country)  
 14. Maiden name Catharine Goodman  
 15. Birthplace Covington (City, town, or county) Texas (State or foreign country)

16. (a) Informant's own signature Julia Turner  
 (b) Address 1722 Webster

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-1940 (Month) (Day) (Year)  
 (c) Place: burial or cremation Greely Wood Cemetery

18. (a) Signature of funeral director H. Thomas  
 (b) Address 2734 Sheridan Ave

19. (a) AUG 16 1940 (Date of local registrar) (b) J. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 21  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2930 Thomas Street  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 12  
 year 1940 hour 9 minute 47 P. M.

21. I hereby certify that I attended the deceased from 2-15- 1940, to 8-12- 1940;  
 that I last saw him alive on 8-12- 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Luetic Heart Disease One year

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature Allen C (M. D. or other) 8-13-1940  
 Address 2601 N. Whittier St. Date signed

WARRANT FURNISH USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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**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.....

*G. L. Howell*

Licensed Embalmer No. ....

*2452*

P. O. Address.....

*2820 Dickson*

**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.**