

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **5083**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....

(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 Mos., 16 Days**
(Specify whether)

In this community
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **000**

(c) City or town **St. Louis, Mo** **1723**
(If outside city or town limits, write "RURAL")

(d) Street No. **1750 Mississippi**
(If rural, give location)

(e) If foreign born, how long in U. S. A. **0** years.

3. (a) PRINT FULL NAME **James Turner**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife **Amonda** 6. (c) Age of husband or wife if alive **26 - 1875** years

7. Birth date of deceased **Aug 26 - 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

65 9 26 hr. min.

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

10. Usual occupation **Rail Road Worker**

11. Industry or business

12. Name **John Turner**

13. Birthplace **Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Russell Turner**

(b) Address **1750 Mississippi**

17. (a) **burial** (b) Date thereof **6/23/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Concordia**

18. (a) Signature of funeral director **W. G. Moyall**

(b) Address **1946 Adams**

19. (a) **JUN 21 1941** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **20**, year **1941** hour **11:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **April 4**, 19**41**, to **June 20**, 19**41**, that I last saw him alive on **June 20**, 19**41**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage, left.**

Due to **arteriosclerosis**

Due to **[Signature]**

Other conditions **[Signature]**
(Include pregnancy within 3 months of death)

Major findings: **None**

Of operations **[Signature]**

Of autopsy **None**

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 **[Signature]** (Specify type of place) (e) Means of injury **[Signature]**

23. Signature **L. V. Mullen** (M. D. **[Signature]**)
Address **1515 Lafayette Ave.,** Date signed **6/20/41**

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, fact should be so stated above.