

FILED FEB 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Abbott  
State File No. 4609

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 142

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield, Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <u>2418 College St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2418 College St.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Sam</u>	b. (Middle)	c. (Last) <u>Turner</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 13, 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 16 1870</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Groceryman</u>	11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Pink Turner</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Lizzie Turner</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>✓ ?</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Lizzie Turner</u> ADDRESS <u>Springfield, Mo.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Asphyxiation &amp; Stenosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>3rd degree burns</u> DUE TO (c) <u>while sleeping in burning bldg.</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Springfield, Greene Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2-13-49 2:45 PM</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Burning</u>
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22. I hereby certify that I attended the deceased from 19 to 2-13-49, that I last saw the deceased living on 2-13-49, and that death occurred at 3:45 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. Abbott M.D. CORNER</u>	23b. ADDRESS <u>219 1/2 E. Walnut Springfield, Mo.</u>	23c. DATE SIGNED <u>2-13-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2/15/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>2-15-49</u>	REGISTRAR'S SIGNATURE <u>W.E. Handley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman H. Lohmeyer</u> ADDRESS <u>Springfield, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed *This Body Was Not Embalmed*

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.