

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>3308</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>18 yrs.</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3406 Hickory St.</b>				e. STREET ADDRESS (If rural, give location) <b>3406 Hickory Street</b> <b>21890</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Jessie</b>		b. (Middle) _____		c. (Last) <b>Turner</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 9, 1954</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Feb. 9 1901</b>	
9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Corinth, Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Primus Bramlett</b>			13b. MOTHER'S MAIDEN NAME <b>Condalia Aug Turner</b>			14. NAME OF HUSBAND OR WIFE <b>Turner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Page Shepard 3406 Hickory St.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CORONARY OCCLUSION</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>ONE DAY</b> <b>5 YEARS</b> <b>ONE MONTH</b>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>ARTERIOSCLEROSIS, GENERALIZED</b>				<b>5 YEARS</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>4200</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____			
22. I hereby certify that I attended the deceased from <b>MARCH 19, 1954</b> to <b>APRIL 9, 1954</b> , that I last saw the deceased alive on <b>APRIL 9, 1954</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Robert G. Hall M.D.</b>				23b. ADDRESS <b>3902 LAFAYETTE St. Louis, Mo.</b>		23c. DATE SIGNED <b>April 12, 1954</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>4/14/1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>APR 14 1954</b>		REGISTRAR'S SIGNATURE <b>J. Cash Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Charles J. Gates 4107 Finney Ave.</b>			

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.....

Signature of Student Embalmer

Signed

Arthur R. Heilliard

Licensed Embalmer No....4221

P. O. Address .....4107. Finn

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.