

No. 300
10-48

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31604

State File No.

BIRTH NO. 72549-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8065

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL			
e. STREET ADDRESS (If rural, give location) 23 1644 Texas			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) BRIAN	b. (Middle) KIM	c. (Last) TURNER	AUGUST 6, 1955		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH AUG. 4, 1955		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) 0	
				12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME ROY TURNER		13b. MOTHER'S MAIDEN NAME PRICILLA WEST		14. NAME OF HUSBAND OR WIFE NONE	
---	--	---	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORD		ADDRESS	
---	--	--	--	---	--	---------	--

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 69 hrs.	
--	--	--	--	--	--	--	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 776*				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	
--	--	--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 8-4-55 19, to 8-6-55, 19, that I last saw the deceased alive on 8-5-55, 19, and that death occurred at 7:00 P m., from the causes and on the date stated above.

23a. SIGNATURE Don B. Klink		(Degree or title) M.D.		23b. ADDRESS 1515 Lafayette		23c. DATE SIGNED 8-8-55	
---------------------------------------	--	-------------------------------	--	---------------------------------------	--	-----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 9-30-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
---	--	-----------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REG. SEP 14 1955		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Rowland-Aker Mortuary Service	
--	--	---	--	--	--	---	--

(Licensed Embalmer's Statement on Reverse Side) Indolite Ave. St. Louis 10, Mo.

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.....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.
If this body is not embalmed, fact should be so stated above.