

39763

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 9 1956

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1378

1. PLACE OF DEATH
a. COUNTY Buchanan

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.)
a. STATE Missouri b. COUNTY Buchanan

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph

c. CITY OR TOWN St. Joseph

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION 1603 So 10th Street

e. STREET ADDRESS (If rural, give location) 1603 So 10th Street *01110*

3. NAME OF DECEASED (Type or Print)
a. (First) Mary b. (Middle) R. c. (Last) Turner

4. DATE OF DEATH (Month) (Day) (Year) Dec 25 1955

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH Jan. 8, 1871

9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (City and State or Foreign Country) Faucett Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Edwards

13b. MOTHER'S MAIDEN NAME Martha Bush

14. NAME OF HUSBAND OR WIFE John Turner (De)

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 ADDRESS Lavina Garrison St. Joseph, Mo

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) Cerebral Hemorrhage with Right Hemiplegia
ANTECEDENT CAUSES
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 331X

INTERVAL BETWEEN ONSET AND DEATH 1 week

Unk.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

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)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/2 1954 to 12/25, 1955, that I last saw the deceased alive on 12/24, 1955, and that death occurred at 5:22 Am from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. F. Mundy M.D.

23b. ADDRESS 2801 Sacramento St. Joseph, Missouri

23c. DATE SIGNED 12/26/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/27/55

24c. NAME OF CEMETERY OR CREMATORY Turner Cemetery

24d. LOCATION (City, town, or county) (State) Wallace MO

DATE REC'D BY LOCAL REG. Jan 3, 1956

REGISTRAR'S SIGNATURE Richard M. Allison

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John P. Papp, St. Joseph, Mo

(Licensed Embalmer's Statement on Reverse Side)

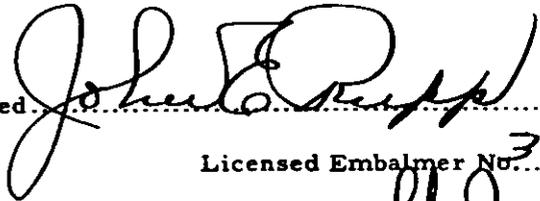
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6.300
0.48

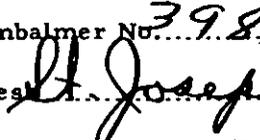
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~by~~, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 398

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.