

Health, Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25401
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 281

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence 1701 Price</u>		d. STREET ADDRESS (If outside, give location) <u>1701 Price</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CECIL</u> Middle <u>A</u> Last <u>TURNER</u>			4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 24, 1902</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>I. S. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Ripley County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>WILLIAM P. TURNER</u>			14. MOTHER'S MAIDEN NAME <u>AMANDA BELLE KREIGBAUM</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Cecil A. Turner</u> Address <u>Hannibal Missouri</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>6 MONTHS</u> <u>2 YEARS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CARCINOMATOSIS</u>	
	DUE TO (c) <u>BRONCHIO-GENIC CARCINOMA</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>162X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>HANNIBAL, MARION, MO.</u>	COUNTY <u></u> STATE <u></u>
21. I attended the deceased from <u>12/19/56</u> to <u>7/25/57</u> and last saw ^{her} him alive on <u>7/25/57</u> Death occurred at <u>7:35 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. N. Watterschew M.D.</u> (Degree or title)	22b. ADDRESS <u>Hannibal, Mo</u>	22c. DATE SIGNED <u>7/27/57</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/27/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>
24. FUNERAL DIRECTOR <u>Hermonford Smith</u> ADDRESS <u>Hannibal Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-31-57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. ...</u>	

(Licensed Embalmer's Statement on Reverse Side)

89-0

RECEIVED

AUG 9 1957

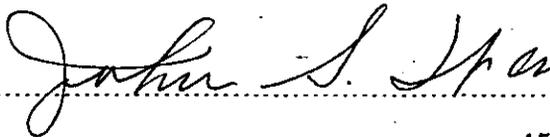
MARION CO. HEALTH DEPT

DATE FILED AUG 9 1957

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. 45

P. O. Address Hannibal

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.