

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010447
STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 46

300
1-57

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) LOUISIANA		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN EOLIA ⁶⁸⁻²⁰
c. FULL NAME OF (If NOT in hospital, give location) PIKE COUNTY HOSP.		Length of stay in lb 2WKS	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last ALLEN WHITE TURPIN			4. DATE OF DEATH Month Day Year MAR. 30 1959		
---------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 3 1870	9. AGE (Years at birthday) 88	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; give if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) BIG ISLAND-VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA
--------------------------------------------------------------------------------------------------------------	-----------------------------------	--------------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME JAMES TURPIN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MARY TURPIN
-------------------------------------------	---------------------------------------------	---------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (un) known) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MRS. ALPHA MAGRUDER WHITESIDE MISSOURI
---------------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia & Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 6 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic Cardiovascular	10 yrs
	DUE TO (c) Renal disease	10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT. SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE
-----------------------------------------------------------	---------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------

21. I attended the deceased from Death occurred at	3/22/59 to 3/30/59 and last saw ^{her} _{him} alive on 3/30/59 5:55P m on the date stated above; and to the best of my knowledge, from the causes stated.
-------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

22a. SIGNATURE (Degree or title) Chas H. Luellen	22b. ADDRESS M. D. Louisiana, Missouri	22c. DATE SIGNED 4/1/59
------------------------------------------------------------	--------------------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APRIL 1, 1959	23c. NAME OF CEMETERY OR CREMATORY EOLIA CEMETARY	23d. LOCATION (City, town, or county) (State) EOLIA MO
------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------	------------------------------------------------------------------

24. FUNERAL DIRECTOR COLLIER FUNERAL SERVICE	ADDRESS Eolia Mo.	25. DATE RECD. BY LOCAL REG. 4-4-59	26. REGISTRAR'S SIGNATURE Bernice Collier
--------------------------------------------------------	-----------------------------	-----------------------------------------------	-----------------------------------------------------

Doctor, coroner, etc: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.