

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034846

FILED VS OCT 8 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2541 STATE FILE NUMBER

| | | | | | | |
|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis City | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch, Mo. | | Length of stay in 1b 13 days | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rob't Koch Hospital | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2233 University | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Paul Middle Burnas Last Turner | | | 4. DATE OF DEATH Month 9 Day 20 Year 59 | | | |
| 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 10-10-05 | 9. AGE (last birthday) 53 | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Auto Repair | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Frank Turner | | 13b. MOTHER'S MAIDEN NAME Stella Inabinent | | 14. NAME OF HUSBAND OR WIFE Dorothy Turner | | |
| 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. 498-05-5266 | 17. INFORMANT Address Records Koch Hosp. Koch, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma of Lung DUE TO (b) Metastasis DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Tbc PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year | 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 | | COUNTY STATE | | |
| 21. I attended the deceased from 98-59 , to 9-20-59 and last saw him alive on 9-20-59 Death occurred at 7:10 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE H.A. Harris MD (Type or print) | | | 22b. ADDRESS Koch Hospital, Koch, Mo | | 22c. DATE SIGNED 9-21-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9-24-59 | 23c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | | |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington | | | ADDRESS | 25. DATE RECD. BY LOCAL REG. 9-24-59 | 26. REGISTRAR'S SIGNATURE Jahn C. Murphy MD | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 W. W. Wilkerson

Licensed Embalmer No. 3575

P. O. Address 17 Lane

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.