

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035209

FILED VS NOV 2 1959

38

Registration District No. _____ Primary Registration District No. **3006**

Registrar's No. **515**

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Boone	b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Columbia	a. STATE Mo.	b. COUNTY Jasper
Length of stay in 1b 19 DAYS		c. CITY OR TOWN Webb City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION UNIVERSITY OF MO. MEDICAL CENTER		d. STREET ADDRESS 734 Prospect	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First Donnie	Middle TURNER	Last Trumble	Month 10	Day 26
			Year 59	

5. SEX FEMALE	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-10-96	9. AGE (last birthday) 63	IF UNDER 1 YEAR	IF UNDER 24 HR
			Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lawrence Co., Mo.	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME JAMES TURNER	13b. MOTHER'S MAIDEN NAME Minnie Hillhouse	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT UNIVERSITY OF MO. MEDICAL RECORDS	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Massive Gastro-intestinal Bleeding		10 wks?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of Stomach	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from **10-7-59** **to** **10-26-59** **and last saw her** **10-26-59** **him** **slive** **on** **10-26-59**
Death occurred at **2:45 AM** **on** **the date stated above, and to the best of my knowledge, from the causes stated.**

22a. SIGNATURE Robert E. Stuffleman M.D.	(Degree or title)	22b. ADDRESS Univ. of Mo. Med. Center	22c. DATE SIGNED 10-26-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/26/59	23c. NAME OF CEMETERY OR CREMATORY Columbia Mo	23d. LOCATION (City, town, or county) Webb City Missouri
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24. FUNERAL DIRECTOR Parker Funeral Service	ADDRESS Columbia Mo	25. DATE RECD. BY LOCAL REG. Oct 26 1959	26. REGISTRAR'S SIGNATURE Mrs R E Palmer
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 25 1959 SA

NOV 20 1959 SA

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 Charles L. Fournier

Licensed Embalmer No. 413

P. O. Address Osborne

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.