URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-042640
STATE FILE NUMBER

FILED VS NOV 19 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9496

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION: St.Louis City Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4166 Washington
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Norma; Middle: Jane; Last: Turner
4. DATE OF DEATH: Month: October; Day: 16; Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: 8/29/1938
9. AGE (last birthday): 21
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St.Louis,Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: James G.Turner
13b. MOTHER'S MAIDEN NAME: Gladys Knight
14. NAME OF HUSBAND OR WIFE: Carl Koebe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James G.Turner, Address: 3501 Lemp Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Hemorrhagic Gastritis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 543X
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 _____ to _____ and last saw her/him alive on _____
Death occurred at 355 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Paul J Simon (Degree or Title: Deputy Coroner)
22b. ADDRESS: 300 Clark
22c. DATE SIGNED: 10/16/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-19-59
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis Co.,Mo.

24. FUNERAL DIRECTOR: Albert H.Hoppe,Inc.,4700 Washington Blvd.
ADDRESS
25. DATE RECD. BY LOCAL REG.: OCT 16 '59
26. REGISTRAR'S SIGNATURE: Ford Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Gary W Wilkinson

Signature of Student Embalmer

Licensed Embalmer No. 357

P. O. Address St Louis

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