

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013264

FILED VS MAR 25 1960

2 3077

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN East Prairie Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 209 N. Martin Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARIE Middle TURNER Last STEINBECK			4. DATE OF DEATH Month MARCH Day 11 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/15/1915	9. AGE (last birthday) 44	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (City and state or country) Wickliffe, Ky.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Marion Turner		13b. MOTHER'S MAIDEN NAME Mary Unknown		14. NAME OF HUSBAND OR WIFE Unavailable		
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. Unavailable		17. INFORMANT Elbert Steinbeck, E. Prairie, Mo. Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF CERVIX WITH WIDESPREAD METASTASES		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		171x
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 checked="" 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. _____	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 **APRIL 30, 1958** to **MARCH 11, 1960** and last saw her/him alive on **MARCH 11, 1960**
 Death occurred at **6:59 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. O. Vermillion, M.D.</i> (Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/12/60 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-16-60	23c. NAME OF CEMETERY OR CREMATORY W.O.W. Cemetery
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.		23d. LOCATION (City, town, or county) East Prairie, Mo.

25. DATE RECD. BY LOCAL REG. **MAR 16 1960**

26. REGISTRAR'S SIGNATURE
Carl Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF TEXAS

X

ADMINISTRATIVE

STATE OF TEXAS

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

PLACE

PLACE

PLACE

PLACE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Stanley H. Difo

Licensed Embalmer No. 419

P. O. Address St. Louis

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.

STATE OF TEXAS