

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000393

FILED VS FEB 14 1961

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134

STATE FILE NUMBER

WRITE STUB
AMENDED
DATE AMENDED
172
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3X
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
BY AFFIDAVIT OF
Wm B. Rast, M.D. Medical Certification
ITEM NO. SHOULD READ

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

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>Life</i>	c. CITY OR TOWN <i>St. Joseph</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Methodist Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>108 E. Valley St.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>David</i> Middle <i>A.</i> Last <i>Turner Jr.</i>			4. DATE OF DEATH Month <i>February</i> Day <i>2</i> Year <i>1961</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 17, 1882</i>
9. AGE (last birthday) <i>79</i>		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) <i>Foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Serum Mfg. Plant</i>	11. BIRTHPLACE (City and state or country) <i>St. Joseph, Missouri</i>
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13a. FATHER'S NAME <i>David A. Turner</i>	
13b. MOTHER'S MAIDEN NAME <i>Elizabeth McLaren</i>		14. NAME OF HUSBAND OR WIFE <i>Luetta Turner</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Address <i>Lewis A. Turner 2106 Manchester</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C.V. A Haemorrhage</i> DUE TO (b) <i>Hypertensive Arteriosclerotic</i> DUE TO (c) <i>Cardio-Vascular disease.</i> 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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <i>1-8-51</i> to <i>2-2-61</i> and last saw him alive on <i>2-2-61</i> Death occurred at <i>10:50 a</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Wm B. Rast M.D.</i>		22b. ADDRESS <i>316 No 10th St Joseph Mo</i>	
22c. DATE SIGNED <i>2-3-61</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE <i>Feb. 4, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>	
23d. LOCATION (City, town, or county) (State) <i>St. Joseph Mo</i>		24. FUNERAL DIRECTOR ADDRESS <i>Clark Funeral Home St. Joseph, Mo.</i>	
25. DATE RECD. BY LOCAL REG. <i>Feb. 6, 1961</i>		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Standell</i>	

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 Earl A. Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph

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.