

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042982

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10868**

AMENDED

FILED DEC 1 1961

DATE TIME

ORDER OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY		c. CITY OR TOWN <b>Murphysboro</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis-Little Rock Hospital, Inc.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>413 N. 22nd St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Richard</b> Last <b>Turnage</b>				4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1961</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-15-1895</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Passenger Agent, Yardmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Alto Pass, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Henry J. Turnage</b>			13b. MOTHER'S MAIDEN NAME <b>Zora Medglin</b>		14. NAME OF HUSBAND OR WIFE <b>Zora Jones Turnage</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			17. INFORMANT <b>Bill Turnage, Murphysboro, Illinois</b>		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) <b>Carcinoma of Lung (RT)</b>							INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) <b>Metastasis to Liver</b>								
DUE TO (c) <b>163x</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cholelithosis, pericardial adhesions</b>					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 <b>Nov. 18, 1961</b> to <b>November 21, 1961</b> and last saw him alive on <b>Nov. 21, 1961</b>				Death occurred at <b>12:15 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>Bill Turnage</i>			(Degree or title)		22b. ADDRESS <b>1755 S. Grand Blvd.</b>		22c. DATE SIGNED <b>11-22-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-24-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Alto Pass Cemetery</b>		23d. LOCATION (City, town, or county) <b>Alto Pass, Illinois</b>			(State)
24. FUNERAL DIRECTOR <b>Crawshaw Funeral Home, Murphysboro, Ill.</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>NOV 22 1961</b>		26. REGISTRAR'S SIGNATURE <i>Lois Smith, M.D.</i>	

