

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-000432**

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 133

**FILED FEB 13 1962**

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 SHOULD READ  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Lafayette</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>34 10m 1d</u>	c. CITY OR TOWN <u>Lexington</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Edna</u> Last <u>Turner</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1876</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>	11. BIRTHPLACE (City and state or country) <u>Mirard Kan</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>J. W. Soule</u>		13b. MOTHER'S MAIDEN NAME <u>Jemie Bueman</u>		14. NAME OF HUSBAND OR WIFE <u>George Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT Address <u>George Turner Lexington Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart Disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Chr. Brain Syndrome associated cerebral arteriosclerosis.</u>					INTERVAL BETWEEN ONSET AND DEATH
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 <u>Feb 3 62</u> to <u>Feb 4 62</u> and last saw her/him alive on <u>Feb 3 - 62</u> Death occurred at <u>5:00 PM Feb 4 62</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Forrest Thomas M.D.</u>			22b. ADDRESS <u>St. Joseph No 2 Lafayette Mo</u>		22c. DATE SIGNED <u>2-4-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/6/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Machpelah Cemetary</u>		23d. LOCATION (City, town, or county) (State) <u>Lexington Mo</u>	
24. FUNERAL DIRECTOR <u>Vaughn-Walker Lexington, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 6, 1962</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>	

MEDICAL CERTIFICATION  
E. Thomas, M.D.

**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 Harold L. Walker

Licensed Embalmer No. 2588

P. O. Address Leipzig, Mo.

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.