

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-001224

FILED JAN 23 1963

Registration District No. 128 Primary Registration District No. 2 Registrar's No. 83

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59  
6397  
21070  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>TEXAS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>SPRINGFIELD</b>		Length of stay in 1b <b>1 WEEK</b>	c. CITY OR TOWN <b>CABOOL</b>
c. FULL NAME OF (If NOT in hospital, give location) <b>ST. JOHNS HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>CABOOL MISSOURI</b>
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>IRWIN</b> Last <b>TURNER</b>			4. DATE OF DEATH Month <b>JAN</b> Day <b>14</b> Year <b>1963</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>4-14-1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>landscape gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ENGLAND</b>	9. AGE (last birthday) <b>70</b>
13a. FATHER'S NAME <b>WILLIAM TURNER</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	12. CITIZEN OF WHAT COUNTRY <b>ENGLAND</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>WILLIAM TURNER FT. SMITH, ARK.</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, rt. upper lobe.</b> DUE TO (b) <b>postoperative partial gastric</b> DUE TO (c) <b>resection for gastric ulcer</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
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.	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>7 Jan 63</b> to <b>14 Jan 63</b> and last saw him alive on <b>13 Jan 1963</b> . Death occurred at <b>5 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>William W Wood MD</b>		22b. ADDRESS <b>Springfield, Mo.</b>	22c. DATE SIGNED <b>1/16/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-16-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CABOOL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>CABOOL MISSOURI</b>
24. FUNERAL DIRECTOR <b>ELLIOTT * GENTRY</b>		25. DATE RECD. BY LOCAL REG. <b>1-22-63</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Meeton</b>

USE BLACK INK OR TYPEWRITER RIBBON

AUG 20 1963

11:00  
11:00  
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Permit 1-14-63

**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 Bess M. Abbott

Licensed Embalmer No. 5115

P. O. Address Springfield 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.