

FILED MAR 4 2 1940

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G-Phillips  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
Unknown (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(g) State Missouri (h) County \_\_\_\_\_  
(c) City or town St Louis **5**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5819 Etzel  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 26  
year 1940 hour 7:10 minute P M.

21. I hereby certify that I attended the deceased from  
January 20, 1940, to January 26, 1940  
that I last saw him alive on January 26, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Asthma  
Duration 2-3yrs

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (d) Means of injury \_\_\_\_\_  
23. Signature H. J. Lyman (M. D. or other) \_\_\_\_\_  
Address 2601 O Whittier Date signed \_\_\_\_\_

3. (a) PRINT James Turner  
FULL NAME

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 498-09-5520

4. Sex Male 5. Color or race ed. 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Maggie Turner 6. (c) Age of husband or wife if alive 49 years  
7. Birth date of deceased abt. 1878  
(Month) (Day) (Year)

8. AGE: abt. 62 Years Months Days If less than one day  
hr. min.

9. Birthplace St Charles Mo-0  
(City, town, or county) (State or foreign country)

10. Usual occupation Painter 9

11. Industry or business 9

MOTHER FATHER { 12. Name Unknown  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Maggie Turner

(b) Address 1125 N. Sarah

17. (a) Burial (b) Date thereof 2-2-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Mammal

(b) Address 4059 Finney ave

19. (a) FEB 2 1940 (b) \_\_\_\_\_  
(Date received local Registrar) (Registrar's Signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....

*William C. McDowell*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*William C. McDowell*

Licensed Embalmer No.....

*2117*

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**