

Registration District No. 701

Primary Registration District No. 1003

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Mexico  
(If outside city or town limits, write "RURAL") NR  
(d) Street No. 529 So. Clark St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10  
year 1940 hour 7 minute 40 a. m.  
21. I hereby certify that I attended the deceased from 1936  
\_\_\_\_\_, 19\_\_\_\_, to 2/10, 1940  
that I last saw her alive on 2/10, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Plaque in Heart Dissected  
Myocardial Infarction  
Due to Arterio Sclerosis & Spuffing

Duration  
3 1/2 hr

3. (a) PRINT FULL NAME 656 Lena Turner

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ned 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Nov 13 1879  
(Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Audrian Co.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business William Wright

12. Name William Wright

13. Birthplace Callaway Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Guv

15. Birthplace Sterling Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Ned Turner  
(b) Address Mexico, Mo.

17. (a) Removal (b) Date thereof 2-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mexico, MO.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) FEB 11 1940  
(Date received local registrar)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Same as above.

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) (e) Means of injury \_\_\_\_\_

23. Signature Albert H. Hoppe (M. D. or other) \_\_\_\_\_  
Address 529 N. Grand Date signed 2/11/40

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

L. Wood

Missouri

*See affidavit # 267*

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**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.....

.....; Registered Apprentice No.....  
working under my personal supervision.

Signed *Guy W Wilkinson*  
Licensed Embalmer No. *3575*

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.**