

D. 2  
13-40  
7-39  
X23159

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 5533

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:  
Enroute City Hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 3 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2139 Cass Ave  
(If rural, give location)  
(e) No Attending Physician  
(f) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME John Turner (alias)  
John Jerrold  
(b) If veteran, name war Unknown (c) Social Security No. Unknown

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 3  
year 1944 hour 5:30 minute AM

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Florence Jerrold 6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased March 7 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
20 3 25 hr. \_\_\_\_\_ min.

Immediate cause of death Coronary Sclerosis  
Due to Arteriosclerosis

9. Birthplace St. Francois Co., Missouri  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Bricklayer

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

11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
Arteriosclerosis

16. (a) Informant Dayton Lee Turner  
(b) Address 2139 Cass Ave.  
17. (a) Burial (b) Date thereof 7/7/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park

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? \_\_\_\_\_

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Ave.  
19. (a) III (b) J. J. Bredich  
(Date received from informant) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature James J. P. [Signature] (M. D. or other) 5  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

**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.....

*Welford N. Burdette*

..... Licensed Embalmer No. 4202.....

..... P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**