

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
 Registrar's No. **3983**

LED MAY 7 1943  
 Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
 (a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Homer G. Phillips Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
 (Specify whether \_\_\_\_\_)  
 In this community 20 years  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County 000  
 (c) City or town St. Louis,  
1221  
921  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 107 N. Ewing  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sam Turner

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

4. Sex Male 5. Color or Race Negro 6. (a) Single, widowed, married, divorced, Widower

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 4, 1884  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>3</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation Sign Painter

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Sam Turner

13. Birthplace Va.  
 (City, town, or county) (State or foreign country)

14. Maiden name Florence Green

15. Birthplace Va.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith  
 (b) Address 2601 N. Whittier St.

17. (a) ~~Antemortem burial~~ Date thereof 4-14-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Washington

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address 3560 Rutledge St.

19. (a) APR 20 1943 (b) J. Z. Brubaker  
 (Date received local Registrar's certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7,  
 year 1943 hour 1 minute 20 P. M.

21. I hereby certify that I attended the deceased from April  
5, 1943 to April 7, 1943  
 that I last saw him alive on April 7, 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Prob. Luetic Heart Disease

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

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

Other conditions \_\_\_\_\_  
 (Includes pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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 Alva Moore (M. D. or Other) \_\_\_\_\_  
 Address 2601 Whittier Date signed 4/17/43

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

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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.....

Licensed Embalmer No.....

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, fact should be so stated above.