

S. No. 2
DOM-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30476

State File No. _____

FILED OCT 13 1943 318

Registration District No. _____ Primary Registration District No. 1003

Registrar's No. 8690

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 Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Hrs
(Specify whether _____)

In this community 3 Yrs.
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. 1220 Missouri Avenue
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Darve Turner

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fem 5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nelson Turner

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Abt. 1911
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Abt. 32 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Mann Pertle

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

14. Maiden name Venie (Unk)

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

16. (a) Informant Nelson Turner

(b) Address 1811 Russell, E. St. Louis, Ill

17. (a) Removal (b) Date thereof 10/2/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jackson, Tenn.

18. (a) Signature of funeral director R. M. C. Green

(b) Address 3517 Laclede Ave.

19. (a) OCT 1 1943 (b) J. F. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28
year 1943 hour 5 minute 10 P.

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.

Immediate cause of death Ruptured aneurysm in the left ventricular wall anterior branch of left coronary artery

Due to arteriosclerosis

Due to _____

Other conditions of 6
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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 [Signature] (M. D. or other) _____

Address [Signature] Date signed 9/30/43

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

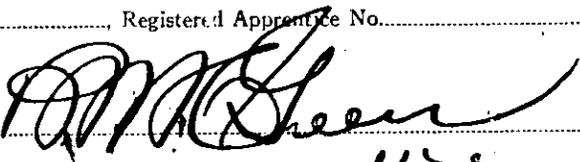
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 1173

P. O. Address 3517 Baldeau

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.