

FILED SEP 30 1944
 318

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **8103**

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:
De Paul 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

3. (a) PRINT FULL NAME **John L. Turner**
 3. (b) If veteran, name war **World War 1** 3. (c) Social Security No. **493-10-4078**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **October 19 1894**
(Month) (Day) (Year)

8. AGE: Years **49** Months **11** Days **2** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Machine & Tool Co.**

11. Industry or business **Machine & Tool Co.**
 12. Name **Joseph Turner**
 13. Birthplace **Maryland**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary Harrigan**
 15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Nellie Turner**

(b) Address **4633 Margaretta Ave.**
 17. (a) **Burial** (b) Date thereof **9/23/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Stroot-Carroll**
 (b) Address **4600 Natural Bridge Ave.**

19. (a) **SEP 21 1944** (b) **J. H. Predeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **St. Louis**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4633 Margaretta Ave.**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **21**
 year **1944** hour **12** minute **30** **A** M.
 21. I hereby certify that I attended the deceased from **10/25**, 19**44**, to **9/21**, 19**44**
 that I last saw him alive on **9/25** and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of liver** Duration **18 mo**

Due to **Chronic myocarditis**
 Due to **Porta obstructions**

Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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) (c) Means of injury _____

23. Signature **Wm. Simpson** (M. D. or other) **MD**
 Address **3333 Washington** Date signed **9/21/44**

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

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.