

Registration District No.

Primary Registration District No.

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: St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain  
(c) City or town Mexico  
(If outside city or town limits, write "RURAL")  
(d) Street No.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Sharon Turner

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

4. Sex Female 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 February 21 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
10 15 hr. min.

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

10. Usual occupation Infant

11. Industry or business

12. Name Pierce E. Turner  
13. Birthplace Coin Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Donna M. Brandt  
15. Birthplace Favette Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Pierce Turner  
(b) Address Mexico, Missouri

17. (a) Burial (b) Date thereof 1-8-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Favette, Missouri

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.

19. (a) JAN 9 1945 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6<sup>th</sup> day January  
year 1945 hour 12 minute 15 P. M.

21. I hereby certify that I attended the deceased from Nov. 20 1944 to Jan. 6 1945  
that I last saw her alive on January 6 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hydrocephalus, Congenital  
Due to  
Due to

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

Major findings: Of operations Same  
Of autopsy Same

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) M.D.  
Address 4952 Maryland Ave Date signed 1/6/45

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

4  
NR 2

Duration

MOTHER FATHER

844

St Louis, Mo

21A  
812

21A  
812

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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 *Albert A. Happe*

Licensed Embalmer No. *1861*

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.**