

FILED FEB 13 1945

Registration District No. **377**

Primary Registration District No. **6076**

Registrar's No. **2969**

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town RURAL  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
MANCHESTER NURSING HOME + Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days 4  
Specify whether

In this community 5 days  
years, months or days

3. (a) PRINT FULL NAME WILLIAM TURTON

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife Minnie Turton

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

7. Birth date of deceased November 3 1865  
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 0 If less than one day hr. min.

9. Birthplace Unknown England 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Coal Miner

11. Industry or business Retired

MOTHER FATHER

12. Name Unknown

13. Birthplace Unknown England 4  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown England 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Raymond McCluskey

(b) Address Carterville, Ill.

17. (a) Removal (b) Date thereof 2-5-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carterville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) FEB 6 1945 (b) E. J. Maloney  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County Madison 999

(c) City or town GLEN CARBON 11  
(If outside city or town limits, write "RURAL")

(d) Street No. - (If rural, give location) U

(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 3  
year 1945 hour 12 minute 30 PM.

21. I hereby certify that I attended the deceased from Jan 30  
1945 to Feb 3 1945  
that I last saw him alive on Feb 3 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

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

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

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

Major findings:  
Of operations A 30

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

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

Signature A. J. Merklin (M. D. or other) \_\_\_\_\_  
Address 3507 Potomac Date signed \_\_\_\_\_

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

600

**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 L. Hoppe*

Licensed Embalmer No.....

2971

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.**