

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

**FILED MAR 23 1945**

Registration District No. **818** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

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

(d) Length of stay: In hospital or institution 1 mo. 4 days  
(Specify whether years, months or days)

In this community 22 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17

(c) City or town St. Louis, 9 21  
(If outside city or town limits, write "RURAL")

(d) Street No. 2031 Division  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Webster Turner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 498-10-7047

4. Sex Male 5. Color or Race Negro

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

6. (b) Name of husband or wife Mammie Turner 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased May 10 1895  
(Month) (Day) (Year)

8. AGE: Years 49 Months 9 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

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

MOTHER, FATHER { 12. Name Benjamin Turner

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Mammie Turner

(b) Address 2031 Division

17. (a) Burial (b) Date thereof 3-14-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Mary Wade

(b) Address 4202 Fernway Ave

19. (a) MAR 13 1945 J. F. Bluff  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8, year 1945 hour 10 minute 00 P. M.

21. I hereby certify that I attended the deceased from February 2, 1945 to March 8, 1945 that I last saw him alive on March 8, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Autopsy: Bronchopneumonia Duration 3 days

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

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

Other conditions Cardiac Hypertrophy Indef.  
(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)

(e) Means of injury \_\_\_\_\_

23. Signature J. F. Murphy (M. D.) Date signed 3/10/45  
Address 3601 W. ...

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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.....

Robert Lee Cummings..... Registered Apprentice No. ....  
working under my personal supervision.

Signed.....

  
Licensed Embalmer No. 42763

P. O. Address. 4040<sup>e</sup> Aldine

**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.**