

S. No. 2
M-5-43
5-17-39
I X36671

FILED AUG 5 1946
318

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6648

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Missouri Baptist Hospital
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Turner
(d) Street No. Rural
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Denny A. Turner
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced, Infant
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased October 17 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 9 21 hr. min.

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

10. Usual occupation Infant

11. Industry or business
12. Name D.A. Turner
13. Birthplace Turner Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Margene Burnett
15. Birthplace Aurora Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant D.A. Turner
(b) Address Turner, Mo.
17. (a) Burial (b) Date thereof 7-29-46
(c) Place: burial or cremation Springfield, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 800 Washington Blvd.
19. (a) (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 27
year 1946 hour 10 minute 40 P. M.
21. I hereby certify that I attended the deceased from 26 July 46
19 to 28 July 1946
that I last saw him alive on 27 July 46
and that death occurred on the date and hour stated above.

Immediate cause of death
Meningocele
Hydrocephalus.
Due to meningitis type 24 hrs.
Due to undetermined

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
157

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature Robert M. Woolley
Address 4500 Almond St. Date signed 7-28-46
While at work (e) Means of injury

Duration
Time Birth
24 hrs.
PHYSICIAN
Underline the cause to which death should be charged statistically.

8799

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.....

Henry M. Brammer
.....
Licensed Embalmer No. *4200*.....

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.