No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14623

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3301

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: 0
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 2921 Easton Avenue
(If rural, give location)

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

3. (a) PRINT FULL NAME Lucius Turner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Col

6. (a) Single, widowed, married, divorced Sep 1

6. (b) Name of husband or wife
Unknown

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

7. Birth date of deceased August (Month) 24 (Day) 1889 (Year)

8. AGE: Years 57 Months 6 Days ~~8~~ If less than one day hr. min.

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

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER

12. Name Jack Turner

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

14. Maiden name Mary Lenzy

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

16. (a) Informant Elizabeth Rhodes

(b) Address 2601 N Whittier St

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 3-6-47 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Mo

18. (a) Signature of funeral director W Pitts Burke

(b) Address

19. (a) MAR 28 1947 (Date received local registrar) (b) J. F. Breneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1 year 1947 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from 2-22, 1947, to 3-1, 1947, that I last saw him alive on Mar. 1, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Far Advanced Pulmonary Tuberculosis	Undet.
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy None

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Edw. D. Williams (M. D. or other)

Address 2601 N Whittier Date signed 3/4/47

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.