

FILED NOV 7 1947 **318**

**1003**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

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

(d) Length of stay: In hospital or institution 1 month  
(Specify whether)

In this community 30 years  
years, months or days)

3. (a) PRINT FULL NAME Roscoe Turner

3. (b) If veteran, name war.....

3. (c) Social Security No. 495-28-5191

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maggie Turner 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Unavailable 1897  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
Abt	50			br. min.

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

10. Usual occupation Sole cutter

11. Industry or business International Shoe Co.

12. Name Will Turner

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

14. Maiden name Lucinda Martin

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

16. (a) Informant Maggie Turner

(b) Address 3308a Laclede Ave.

17. (a) Burial (b) Date thereof 10-28-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) OCT 21 1947 (b) J. F. Budeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 3308 Laclede  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18  
year 1947 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept. 23 1947 to Oct. 18 1947;  
that I last saw h. im alive on Oct. 18 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Prob. Aneurysm at Base of Brain with Subarachnoid Hemorrhage Undet.

Due to.....

Due to.....

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy none

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?.....  
Means of injury.....

23. Signature Creas J. Daniels (M. D. or other)  
Address 2607 N. Whittier Date signed 10/21/47

PHYSICIAN  
Underline the cause of which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

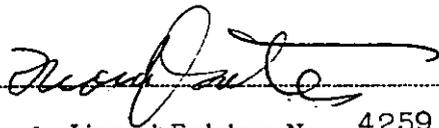
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Thomas J. Gates

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_



Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

**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.