

FILED NOV 28 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10504**

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:.....
Enroute City Hospital 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Illinois** (b) County..... **Macon** **999**
(c) City or town..... **Decatur** **1**
(If outside city or town limits, write "RURAL")
(d) Street No..... **936 N. Main St.** **6**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) **2**
If yes, name country.....

3. (a) PRINT FULL NAME..... **Charles W. Turrentine**
3. (b) If veteran, name war..... **No**
3. (c) Social Security No. **Unknown**

4. Sex..... **Male** 5. Color or race..... **White**
6. (a) Single, widowed, married, divorced..... **Widower**
6. (b) Name of husband or wife..... **Matilda Turrentine**
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... **November 18 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 11 25 ..hr.min.

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

10. Usual occupation..... **Salesman** **1**

MOTHER FATHER

11. Industry or business.....
12. Name..... **Unknown** **9**
13. Birthplace..... **Unknown** **1**
(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..... **Thelma Akers**
(b) Address..... **Collinsville, Ill.**
17. (a) **Removal** (b) Date thereof..... **11-14-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **McLeansboro, Ill.**

18. (a) Signature of funeral director..... **Albert H. Hoppe**
(b) Address..... **4700 Washington Blvd.**

19. (a) **NOV 14 1947** (b) **J. G. Bredich**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **Nov** day..... **13**
year..... **1947** hour..... **4:10** minute..... **P.** M.

21: I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Coronary occlusion
Due to.....
Coronary sclerosis
Due to.....
94
Other conditions.....
(include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause of 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?..... (Specify type of injury)

23. Signature..... **Patrick E. Sawyer** **2**
Address..... **Dr. Sawyer** Date signed..... **11/14/47**

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

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 Elmo P. Caldwell

Licensed Embalmer No. 4077

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.