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MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38715**
Registrar's No. **9926**

FILED DEC 2 1948 **318**
Registration District No.

Primary Registration District No. **1003**

WRITE PLAINLY—USE 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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... **17 days**
(Specify whether
In this community.....
years, months or days)

3: (a) PRINT FULL NAME **Marie Turner**
3. (b) If veteran, name war..... **nil** 3. (c) Social Security No.

4. Sex **Female** 5. Color **Col.** 6. (a) Single, widowed, married **3**
race **Col.** divorced **Divorced**
6. (b) Name of husband or wife **Jim Turner** 6. (c) Age of husband or wife if
alive **abt. 42** years
7. Birth date of deceased..... **2** (Month) **7** (Day) **1915** (Year)

8. AGE: Years **33** Months **9** Days **7** If less than one day
hr. min.

9. Birthplace **Little Rock, Ark.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER
12. Name **John Dicks**
13. Birthplace **Jefferson, Ark.**
(City, town, or county) (State or foreign country)
14. Maiden name **Clara Edgington**
15. Birthplace **Union, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Clara Dicks Adams**
(b) Address **3129 Benton Ave.**

17. (a) **Burial** (b) Date thereof **11-19-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **J. W. Boyce**
(b) Address **4469 Washington Blvd.**

19. (a) **NOV 16 1948** (b) **J. B. Laster**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County..... **000**
(c) City or town **St. Louis** **1-7**
(If outside city or town limits, write "RURAL") **9**
(d) Street No. **2315 Chestnut**
21 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **14**
year **1948** hour **10** minute **5 p. m.**
21. I hereby certify that I attended the deceased from
Oct. 28, 19 **48** to **Nov. 14**, 19 **48**
that I last saw her alive on **Nov. 14**, 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Hypertensive Encephalopathy, Duration **Undet.**

Due to.....
Due to..... **1/25**

Other conditions **Congestion of Liver & Kidney**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy..... **Yes**
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 blow)
While at work..... (e) Means of injury.....
23. Signature **Herbert J. Coover** (M. D. or other)
Address **2601 N Whittier St.** Date signed **11/16/48**

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 *Frederick P. Starks*

Licensed Embalmer No. *4599*

P. O. Address. *St. Louis*

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.