

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35663

BIRTH NO. 69286-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9362

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Infirmary		d. STREET ADDRESS (If rural, give location) 423 1718 Russell	
3. NAME OF DECEASED (Type or Print) a. (First) Martin b. (Middle) Crawford c. (Last) Turner		4. DATE OF DEATH (Month) (Day) (Year) October 6th 1949	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) /	8. DATE OF BIRTH 10-5-49
9. AGE (In years last birthday) 27		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) St. Louis Mo
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Bill Turner		13b. MOTHER'S MAIDEN NAME Nevada Crawford	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Nevada Crawford Turner, 1708 Russell
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity (6 mo. gestation) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 139			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 176X			
22. I hereby certify that I attended the deceased from 10-5, 1949, to 10-6, 1949, that I last saw the deceased alive on 10-6, 1949, and that death occurred at 2:00 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edgar A. Woodson M.D.		23b. ADDRESS 930 N 2ND ST	
23c. DATE SIGNED 10/7/49			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE OCT 31 1949	
24c. NAME OF FUNERAL HOME OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE J. B. Foster	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.