No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED MAR 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11200
Registrar's No. 2633

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: Transit to HOMER G. PHILLIPS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: St Louis 2119
d. STREET ADDRESS (If rural, give location): 4324 Page ave

3. NAME OF DECEASED (Type or Print): a. (First) HELEN b. (Middle) c. (Last) TURNER

4. DATE OF DEATH (Month) (Day) (Year): MAR 14 1950

5. SEX: FEMALE
6. COLOR OR RACE: Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May - - 1837
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Garment Worker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Ark
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Adam Cox
13b. MOTHER'S MAIDEN NAME: Jennie Wilson
14. NAME OF HUSBAND OR WIFE: John H Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: Abraham Wilson **ADDRESS**: 3425 Lasalle

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound of skull and brain, suffered when shot with gun in the hands of one Jay Turner (col) Husband

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) deceased in home 4324 Page

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Blind, about 7:15 pm March 14, 1950

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Homicide
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Homicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21c. (CITY, TOWN, OR TOWNSHIP) St Louis **(COUNTY)** **(STATE)** Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Mar 14 50 7:15 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? E 981 X

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 7:15 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE Patrick E. Taylor (Degree or title) Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 3. 20. 50.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Mar 22
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St. Louis County

DATE REC'D BY LOCAL REG. MAR 20 1950
REGISTRAR'S SIGNATURE: J. B. Lasalle
25. FUNERAL DIRECTOR'S SIGNATURE S.J. Watson **ADDRESS**: 2769 Chouteau

(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 _____

_____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed S. J. Naton

Licensed Embalmer No. 269 P

P. O. Address 2769 Chantic

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

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