

FILED SEP 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr Long 30062
State File No.

Registrar's No. 815

BIRTH NO. 57286-50 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield,		c. CITY (If outside corporate limits, write RURAL and give township) 0390 1	
c. LENGTH OF STAY (in this place) 8 days		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's			

3. NAME OF DECEASED a. (First) Michael b. (Middle) Lee c. (Last) Turner			4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1950		
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant 0	
8. DATE OF BIRTH Sept. 7, 1950		9. AGE (In years last birthday) 8		10. HOURS 8 MIN. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) 0 Springfield, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME George A. Turner		13b. MOTHER'S MAIDEN NAME Janetta Garrison		14. NAME OF HUSBAND OR WIFE Infant	
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. no		17. INFORMANT'S SIGNATURE OR NAME George A. Turner ADDRESS Turners Mo.	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Intestinal Obstruction		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE Congenital Atresia of entire large intestine		MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STOPPING 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.		7562	

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from **9-7**, 19**50**, to **9-14**, 19**50**, that I last saw the deceased alive on **9-14**, 19**50**, and that death occurred at **10A** m., from the causes and on the date stated above.

23a. SIGNATURE Gorman J. Scharf (Degree or title) M.D.		23b. ADDRESS 609 Cherry St		23c. DATE SIGNED 9/15/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sept. 15, 1950		24c. NAME OF CEMETERY OR CREMATORY White Chapel	
24d. LOCATION (City, town, or county) Springfield, Missouri		24e. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. 9-16-50		REGISTRAR'S SIGNATURE W.E. Hagedorn		25. FUNERAL DIRECTOR'S SIGNATURE Gorman-Scharf Funeral Home ADDRESS Springfield, Missouri	

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

396
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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.....

L. Edwin Gorman

Signed.....

Student Embalmer

Licensed Embalmer No.

3177

P. O. Address

Pringfield, Md

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.