

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15603**

NO. 300  
10-48  
JUN 9 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **5120** Registrar's No. **144**

1. PLACE OF DEATH a. COUNTY <b>BOONE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>BOONE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>COLUMBIA</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>COLUMBIA</b>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <b>R.R. #</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <b>XX R.R.#</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>EDWIN</b>	b. (Middle) <b>OSCAR</b>	c. (Last) <b>TURNER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 29 1952</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MARCH 15 1873</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR (Month) (Day) (Year) <b>2 14</b>	IF UNDER 24 HRS. (Hour) (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TELEPHONE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE</b>	11. BIRTHPLACE (State or foreign country) <b>GREENE CO ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>T.C. TURNER</b>	13b. MOTHER'S MAIDEN NAME <b>MARTHA VAN BEBBER</b>	14. NAME OF HUSBAND OR WIFE <b>BERTHA TURNER</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state way or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>495-07-3826</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MRS J. ROSS FLEETWOOD</b>	ADDRESS <b>COLUMBIA</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarct</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Shortly</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atherosclerosis</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 <b>4221</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (Min.)	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 **March 1952** to **May 29, 1952** that I last saw the deceased alive on **May 24, 1952** and that death occurred at **8:30AM** from the causes and on the date stated above.

23a. SIGNATURE <b>E. B. Baskitt M.D.</b>	23b. ADDRESS <b>Columbia Mo</b>	23c. DATE SIGNED <b>5/31/52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>MAY 31 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>CENTRALIA CEM.</b>	24d. LOCATION (City, town, or county) (State) <b>CENTRALIA MO</b>
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DATE REC'D BY LOCAL REG. <b>May 31 1952</b>	REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>R. Quiret</b>	ADDRESS <b>Columbia</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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JUL 29 1952

JUL 1 1952

105  
Carter

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 \_\_\_\_\_

*Lynman H. Spink*

Licensed Embalmer No. \_\_\_\_\_

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.