

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20778

State File No. _____

ED JUN 17 1952

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 243

0485
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, write RURAL and give town OR TOWN Independence) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence <i>1266 S</i> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 419 N. Liberty | | d. STREET ADDRESS (If rural, give location) 419 N. Liberty | |

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|--|--|-------------|--------------------------------------|-----------|--|
| 3. NAME OF DECEASED (Type or Print) MR. GEORGE RICHARDSON TURNER | | | 4. DATE OF DEATH June 8, 1952 | | |
| a. (First) | | b. (Middle) | | c. (Last) | |

| | | | | | | | |
|--------------------|-------------------------------|---|---------------------------------------|---|------------------------|------------------------|------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 19, 1869 | 9. AGE (In years last birthday) 82 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours | IF UNDER 2 MINS. Mins. |
|--------------------|-------------------------------|---|---------------------------------------|---|------------------------|------------------------|------------------------|

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|--|--|-----------------------------------|--|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance-Light Dept. | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) Wayne City, Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
|--|--|-----------------------------------|--|---|--|---|--|

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|---|--|---|--|--|--|--|--|
| 13a. FATHER'S NAME Robert Turner | | 13b. MOTHER'S MAIDEN NAME Maria Richardson | | 14. NAME OF HUSBAND OR WIFE Mrs Anna Catherine Turner | | | |
|---|--|---|--|--|--|--|--|

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|---|--|--|--|---|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 486-36-9866 | | 17. INFORMANT'S SIGNATURE OR NAME Geo. S. Turner ADDRESS Washington | | | |
|---|--|--|--|---|--|--|--|

| | | | | | | | | | |
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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. | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation | | DUE TO (b) Hypertensive Cardiovascular Disease | | | | | | Indefinite | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (c) Uremia | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | | 20. AUTOPSY? 443 X YES <input type="checkbox"/> NO <input 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) | |
|--|--|--|--|---|--|

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

22. I hereby certify that I attended the deceased from 4/28, 1952, to 6/8, 1952, that I last saw the deceased alive on 6/6, 1952, and that death occurred at 9:00 P m., from the causes and on the date stated above.

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|--|--|--------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE E. Shelton, M.D. (Degree or title) | | 23b. ADDRESS 310 S Main | | 23c. DATE SIGNED 6/11/52 | |
|--|--|--------------------------------|--|---------------------------------|--|

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|---|--|--------------------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE June 11, 1952 | | 24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | | 24d. LOCATION (City, town, or county) (State) Indep. Mo. | |
|---|--|--------------------------------|--|---|--|---|--|

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|---|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. 6-11-52 | | REGISTRAR'S SIGNATURE [Signature] | | 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Indep, Mo. | |
|---|--|--|--|---|--|

JUN 1 3 1920

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 Henry J. Mitchell

Licensed Embalmer No. 3925

P. O. Address Independence Mo.

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.