

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **27782**
 Registrar's No. **762-A**

49924
 BIRTH NO. **18 1952**

REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY Green County b. CITY OR TOWN Springfield		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Green	
c. LENGTH OF STAY (In this place) 6 days		c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2106 W. Atlantic		d. STREET ADDRESS (If rural, give location) 2106 W. Atlantic	
3. NAME OF DECEASED (Type or Print) a. (First) TIMOTHY b. (Middle) RALPH c. (Last) TURNER			4. DATE OF DEATH (Month) (Day) (Year) Aug. 14, 1952
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Aug. 8, 1952
9. AGE (In years last birthday) (Month) (Days) 6		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Springfield, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Calbert Turner		13b. MOTHER'S MAIDEN NAME Vivian Weter	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Calbert Turner ADDRESS Springfield, Mo.
MEDICAL CERTIFICATION			
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* (a) Enteritis (According to Coroner's report)	
		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"/>		UNATTENDED BY PHYSICIAN	
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) m.	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 _____ to _____ and that death occurred at 11:00a m., from the causes and on the date stated above.			
23a. SIGNATURE Earl Williams (Degree or title) Deputy Registrar of Vital Statistics		23b. ADDRESS Springfield, Missouri	23c. DATE SIGNED 8/14/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/15/1952	24c. NAME OF CEMETERY OR CREMATORY Fair View Cemetery	24d. LOCATION (City, town, or county) (State) Sparta, Missouri
DATE REC'D BY LOCAL REG. 8/16/52	REGISTRAR'S SIGNATURE Earl Williams	25. FUNERAL DIRECTOR'S SIGNATURE AYRE-GOODWIN FUN'L SERVICE, Spngfld, Mo., ADDRESS	

623 West Walnut
 SPRINGFIELD, MISSOURI
 WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

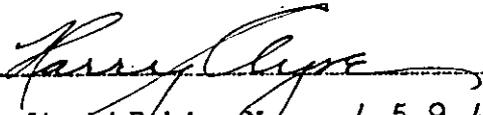
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 4594

P. O. Address Springfield, Missouri

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.