

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7100**

FILED FEB 26 1953

BIRTH NO. _____ REG. DIST. NO. **275** PRIMARY REG. DIST. NO. **3053** Registrar's No. **36**

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY PHELPS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CRAWFORD | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ROLLA | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN STEELVILLE 0280 | |
| c. LENGTH OF STAY (in this place) 1 1/2 DAYS | | d. STREET ADDRESS (If rural, give location) 1 | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION PHELPS Co. MEM. HOSPITAL | | | |

| | | | | | |
|---|-------------------------------|---|-------------------------------------|---|---|
| 3. NAME OF DECEASED (Type or Print) BENJAMIN TURNER | | | 4. DATE OF DEATH Feb-16-1953 | | |
| a. (First) | b. (Middle) | c. (Last) | Month | Day | Year |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 4-16-1874 | | 9. AGE (In years last birthday) 78 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMING | | 11. BIRTHPLACE (City and State or Foreign Country) STEELVILLE, MO. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |

| | | |
|--|---|--|
| 13a. FATHER'S NAME WILLIAM TURNER | 13b. MOTHER'S MAIDEN NAME SARAH HOUSE WRIGHT | 14. NAME OF HUSBAND OR WIFE MARTHA TURNER |
|--|---|--|

| | | | |
|---|--|---|--------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE | 17. INFORMANT'S SIGNATURE OR NAME LARENCE TURNER | ADDRESS STEELVILLE, 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Fibrosarcoma, recurrent with generalized metastases | | INTERVAL BETWEEN ONSET AND DEATH 18 mo. |
| | | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 197X | | |
| | | 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis | | years |

| | | |
|--------------------------------------|---|--|
| 19a. DATE OF OPERATION 3-5-52 | 19b. MAJOR FINDINGS OF OPERATION Generalized fibrosarcoma, ant. abdominal wall | 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) 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 **2-21-**, 19**52**, to **2-16-**, 19**53**, that I last saw the deceased alive on **2-15-**, 19**53**, and that death occurred at **2:45 Am.**, from the causes and on the date stated above.

| | | | |
|---|-------------------|--------------------------------|---------------------------------|
| 23a. SIGNATURE F. L. Royal, M.D. | (Degree or title) | 23b. ADDRESS Belle, Mo. | 23c. DATE SIGNED 2-19-53 |
|---|-------------------|--------------------------------|---------------------------------|

| | | | |
|---|----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE 2-18-1953 | 24c. NAME OF CEMETERY OR CREMATORY STEELVILLE CEM. | 24d. LOCATION (City, town, or county) (State) STEELVILLE, MO. |
|---|----------------------------|---|--|

| | | | |
|--|--|--|--------------------------------|
| DATE REC'D BY LOCAL REG. Feb 19, 1953 | REGISTRAR'S SIGNATURE Nadine L. Stoll | 25. FUNERAL DIRECTOR'S SIGNATURE Pharm. S. Hubert | ADDRESS STEELVILLE, MO. |
|--|--|--|--------------------------------|

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

County Health Officer,
County File Number _____
Date Filed 2-24-53

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 Thomas S. Halbert

Licensed Embalmer No. 4332

P. O. Address STEELVILLE, 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.