

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22130**

FILED JUL 9 - 1953

BIRTH NO. _____ REG. DIST. NO. **385** PRIMARY REG. DIST. NO. **3039** Registrar's No. **358**

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Linn	
b. CITY (If outside corporate limits, write RURAL and give township) Marceline		c. CITY (If outside corporate limits, write RURAL and give township) Marceline 0581 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bunton Rest Home		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Tobias	b. (Middle) T	c. (Last) Turner	4. DATE OF DEATH (Month) (Day) (Year) June 12, 1953
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 17, 1866	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months 5 Days 25	IF UNDER 10 HRS. Hours 0 Mins. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) Thomas Hill, Missouri 0	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Robert Turner	13b. MOTHER'S MAIDEN NAME Mary Hicks	14. NAME OF HUSBAND OR WIFE Eliza
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Hurley Turner	ADDRESS Des Moines, Ia
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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) Cerebral Embolism		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis 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 332X	20. AUTOPSY? 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 1950 to 6-12, 1953** that I last saw the deceased alive on **June 16, 1953** and that death occurred at **10:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert W. Schumacher M.D.	23b. ADDRESS Marceline Mo	23c. DATE SIGNED 6-13-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/13/53	24c. NAME OF CEMETERY OR CREMATORY Roselawn	24d. LOCATION (City, town, or county) (State) Marceline, Mo
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DATE REC'D BY LOCAL REG. 6-13-53	REGISTRAR'S SIGNATURE Mary Jones Owens	25. FUNERAL DIRECTOR'S SIGNATURE John McLaughlin	ADDRESS Marceline Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

81
4

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 _____ X

Student Embalmer No. _____ X

working under my personal supervision.

Student _____ X
Student Embalmer

Signed

George W. Davolt

Licensed Embalmer No.

4799

P. O. Address

Marceline, Mi

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.