

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

3368

FILED JAN 28 1954

318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 0097

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 0097		
1. PLACE OF DEATH a. COUNTY <u>0</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>8 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hanley Hills 4280</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Incarinate Word Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>7926 Wunderhill Dr.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u> b. (Middle) <u>Lee</u> c. (Last) <u>Turley</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1954</u>					
5. SEX <u>0</u> <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 15, 1891</u>		9. AGE (In years last birthday) <u>62</u>	10. MONTHS <u>6</u>	11. DAYS <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.D.S.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Bonne Terre Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Dr. John W. Turley</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Chadburn</u>		14. NAME OF HUSBAND OR WIFE <u>Anna M.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>486-20-5048</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Anna M. Turley 7926 Wunderhill Dr.</u>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis &amp; Emphysema</u>  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.					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>N</u>		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 <u>4222</u>				
22. I hereby certify that I attended the deceased from <u>Dec. 28, 1953, to Jan 4, 1954</u> , that I last saw the deceased alive on <u>Jan 4, 1954</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>R. Berg MD</u> (Degree or title)				23b. ADDRESS <u>3203 S. Grand St. Louis, Mo. 454</u>		23c. DATE SIGNED		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>1/6/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>		
DATE RECEIVED BY LOCAL REG. <u>JAN 5 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Gebken Sons 2630 Gravois Ave.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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 Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

**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.**