

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23526**

BIRTH NO. _____ **REG. DIST. NO.** 174 **PRIMARY REG. DIST. NO.** 3035 **Registrar's No.** 56

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lexington</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mayview</u>	
c. LENGTH OF STAY (In this place) <u>9 days</u>		d. STREET ADDRESS (If rural, give location) <u>1/2 block off main street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memoral Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>1/2 block off main street</u>	
3. NAME OF DECEASED a. (First) <u>Ethel</u> b. (Middle) <u>MAE</u> c. (Last) <u>Turner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 5, 1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 1, 1894</u>
9. AGE (In years last birthday) <u>60</u> MONTHS <u>4</u> DAYS <u>4</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Mayview Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Lee Turner</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Lee</u>	
14. NAME OF HUSBAND OR WIFE <u>Wilburn Turner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Samuel L. Mr. Gertrude Collins</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Diabetes Mellitus</u>		<u>10 yrs</u>	
DUE TO (c) _____		_____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic heart disease and chronic congestive failure</u>		_____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>260X</u>	
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)		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 <u>June 1853</u> , to <u>July 5, 1954</u> , that I last saw the deceased alive on <u>July 5, 1954</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Wilbur E. Holperson M.D.</u>		23b. ADDRESS <u>Higginville Mo.</u>	
23c. DATE SIGNED <u>7-26-54</u>		_____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 11, 1954</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron</u>		24d. LOCATION (City, town, or county) (State) <u>Mayview Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7-30-54</u>		REGISTRAR'S SIGNATURE <u>Wm. E. Eastabrook</u>	
5. EMBELMER DIRECTOR'S SIGNATURE <u>George H. Green</u>		ADDRESS <u>Marshall Mo.</u>	

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

AUG 5 1937

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 George H. Green

Licensed Embalmer No. 4270

P. O. Address Washington

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.