

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25359

FILED AUG 11 1954

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7134**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>JEFFERSON</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>ST LOUIS</b>		c. LENGTH OF STAY (in this place) <b>18 DA</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DEACONESS HOSP.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>DE SOTO</b>	
3. NAME OF DECEASED a. (First) <b>MINNIE T.</b> b. (Middle) _____ c. (Last) <b>TURNER</b>		4. DATE OF DEATH <b>JULY 29 1954</b> (Month) (Day) (Year)	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JAN. 11, 1870</b>
9. AGE (in years last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	11. BIRTHPLACE (State or foreign country) <b>SOMERHILL ILL.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>W M M SHANTON</b>	13b. MOTHER'S MAIDEN NAME <b>ANNA THOMPSON</b>	14. NAME OF HUSBAND OR WIFE <b>W. S. TURNER SR.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Maryon Turner</b> ADDRESS <b>De Soto Mo.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>Arteriosclerotic Heart Disease c</b> <b>Cardiac Decompensation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 Mos.</b>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) <b>Ex. Rt Hip.</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) _____	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		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.) <b>home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>De Soto Mo.</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>7-9-54 ?</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fell at home</b> <b>E9040</b>	
22. I hereby certify that I attended the deceased from <b>July 15</b> , 19 <b>54</b> , to <b>July 29</b> , 19 <b>54</b> , that I last saw the deceased on <b>July 29</b> , 19 <b>54</b> , and that death occurred at <b>2:30</b> m.; from the causes and on the date stated above. <b>21</b>			
23a. SIGNATURE <b>Bernard T. Houdan MD</b> (Degree or title)		23b. ADDRESS <b>106 So Central</b>	
23c. DATE SIGNED <b>7/29/54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BORIAL</b>	24b. DATE <b>AUG 1, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN PARK</b>	24d. LOCATION (City, town, or county) (State) <b>DE SOTO Mo.</b>
DATE REC'D BY LOCAL REG. <b>AUG 2 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Donnell B. Steiner</b> ADDRESS <b>De Soto Mo</b>	

**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.

Signed Donald B. Stetson.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 4104

P. O. Address Del Rio, 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.