

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

No. 300  
10.48

FILED SEP 2 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 247 PRIMARY REG. DIST. NO. 5838 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY <u>Newton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Mo</u> b. COUNTY <u>Newton</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Berwick Twp 56</u>		c. CITY OR TOWN <u>Stark City</u> <sup>Berwick Twp</sup> d. Is Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>10 mile S.W. of Pince City</u>		e. STREET ADDRESS (If rural, give location) <u>10 mile S.W. Pince City</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>DANIEL</u> b. (Middle) <u>AMOS</u> c. (Last) <u>TURNER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 12, 1954</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec 26, 1897</u>		9. AGE (In years last birthday) <u>56</u> <sup>Months</sup> <u>7</u> <sup>Days</sup> <u>19</u> <sup>If under 18, in hours</sup> <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Stark City Mo</u>	
13a. FATHER'S NAME <u>Daniel W. Turner</u>			13b. MOTHER'S MAIDEN NAME <u>Mary G. Carter</u>		14. NAME OF HUSBAND OR WIFE <u>Sue Turner</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Sue Turner</u> ADDRESS <u>Stark City Mo</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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>18 months</u> <u>5 yrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Other cerebral hemorrhage</u> DUE TO (c) <u>Hypertension</u>		
	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 <u>331X</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) 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 June 44, 1954, to Aug 12, 1954, that I last saw the deceased alive on Aug 11, 1954, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Donald R. Kerr MD</u> (Degree or title)	23b. ADDRESS <u>Morett Mo</u>	23c. DATE SIGNED <u>8-7-54</u>
---	-------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 14, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Berwick Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Newton County Mo</u>
---	-------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>Aug 18 1954</u>	REGISTRAR'S SIGNATURE <u>Grace Sanders</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brown</u> ADDRESS <u>Pince City Mo</u>
---	--	---

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

130

**RECEIVED**

District Health Officer No. \_\_\_\_\_

District File Number 854-173

Date Filed AUG 30 1954

NEWTON COUNTY HEALTH UNIT

NEOSHO, MISSOURI

JAN 9 1957

**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~~ Edwin Wilks Student Embalmer No. ~~413~~

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Edwin Wilks

Licensed Embalmer No. 413

P. O. Address Paris City

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.