

FILED NOV 8 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Don. J. Silsby
State File No. 33649

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>1003</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY OR TOWN <u>Turnersfield</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Burge Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>Turners, Missouri 03401</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Albert</u>		b. (Middle) <u>Dillard</u>		c. (Last) <u>Turner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 30, 1954</u>	
5. SEX <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>April 6, 1884</u>	
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 MIN. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>On Farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Turners's Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Albert C. Turner</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Dillard</u>		14. NAME OF HUSBAND OR WIFE <u>Winnie Turner</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Elizabeth Ellis Turner's,</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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic heart disease 6 Mo.</u> INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac insufficiency</u> DUE TO (c) <u>with decompensation 1 wk</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 _____				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) <u>4200</u>			
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>Oct 27, 1954</u> to <u>Oct 30, 1954</u> , that I last saw the deceased alive on <u>Oct 29, 1954</u> , and that death occurred at <u>1:05A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Don J. Silsby M.D.</u>				23b. ADDRESS <u>Springfield Mo</u>		23c. DATE SIGNED <u>10-30-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 31, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Turner's Mo.</u>		24d. LOCATION (City, town, or county) (State) <u>Turner's, Missouri</u>	
DATE RECD BY LOCAL REG. <u>11-1-54</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gorman-Scharpf Funeral Home, Inc. Springfield, Missouri</u>			

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

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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.....
Signature of Student Embalmer

Signed *Leola Garman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield*

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.