

FED NOV 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37640**
5056

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. <u>5056</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u> | | | |
| b. CITY OR TOWN <u>KANSAS CITY</u> | | c. LENGTH OF STAY (in this place) <u>28 yrs.</u> | | c. CITY OR TOWN <u>KANSAS CITY</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1900 E 34th ST</u> | | | | STREET ADDRESS (If rural, give location) <u>54 1900 E 34th ST 3540</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Emma</u> | | b. (Middle) <u>Alice</u> | | c. (Last) <u>Turner</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 30 1954</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>OCT 31, 1872</u> | |
| 9. AGE (In years last birthday) <u>81</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Mts. _____ | | | |
| 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 _____ | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Muncie Ind. 1</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13a. FATHER'S NAME <u>Ephriam HARRald</u> | | 13b. MOTHER'S MAIDEN NAME <u>NARCissia</u> | | 14. NAME OF HUSBAND OR WIFE <u>BATES Andrew Jackson 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>Hazel VANTREase</u> | | ADDRESS <u>X.C. 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. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</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. <u>Generalized Atherosclerosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>33 1/2</u> | |
| 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) _____ | | | |
| 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>July</u> , 19 <u>49</u> , to <u>Oct 27</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>54</u> , and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>P.A. Kienberger M.D.</u> (Degree or title) | | | | 23b. ADDRESS <u>MO 5246 St John</u> | | 23c. DATE SIGNED <u>11-1-54</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>Nov 3, 1954</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cem.</u> | | 24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u> | |
| DATE REC'D BY LOCAL REG. <u>11-1-54</u> | | REGISTRAR'S SIGNATURE <u>new minshall</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sheil FUNERAL Home X.C. MO.</u> | | | |

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.....

Signature of Student Embalmer

Signed.....

James A. Shee

Licensed Embalmer No. *495*

P. O. Address *K. O. Mc*

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.