

No. 300
10-48

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6575**
Registrar's No. **1472**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 0 1 day		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: City Hospital No. 1.		e. STREET ADDRESS (If rural, give location) 2159 2823 Osceola Street	

3. NAME OF DECEASED (Type or Print)		a. (First) PAUL		b. (Middle) EUGENE		c. (Last) TURNER		4. DATE OF DEATH (Month) (Day) (Year) February 11, 1955		
5. SEX Male <input type="checkbox"/>		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH October 9, 1913		9. AGE (In years last birthday) 41 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS.: Hours _____ Mins. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deck Hand			10b. KIND OF BUSINESS OR INDUSTRY LeeWay Freight Co.			11. BIRTHPLACE (City and State or Foreign Country) Pocahantas, Arkansas /			12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Bufford Turner.		13b. MOTHER'S MAIDEN NAME Callie Smith		14. NAME OF HUSBAND OR WIFE Beulah Marie Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War 2		16. SOCIAL SECURITY NO. 432-17-0708		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Beulah Turner, 2823 Osceola Street	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture of skull, Ruptured heart suffered when car overturned & deceased was struck by central band struck utility pole in front of about 3:15 p.m. on Friday about 10:11 p.m.		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Adjusted			
		DUE TO (c) Accident			
		II. OTHER SIGNIFICANT CONDITIONS contributing to the death, not related to the disease or condition above. None			

19a. DATE OF OPERATION Feb 13 1955		19b. MAJOR FINDINGS OF OPERATION Accident		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 13 55 10:11 p.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? E8234	

22. I hereby certify that I attended the deceased from **9:40 p.m.**, 19**55**, to **10:11 p.m.**, 19**55**, that I last saw the deceased alive on **9:40 p.m.**, 19**55**, and that death occurred at **10:11 p.m.**, 19**55**, from the causes and on the date stated above. **31**

23a. SIGNATURE Patrick P. Taylor Parover		(Degree or title)		23b. ADDRESS 31300 Clark		23c. DATE SIGNED 2-16-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb 17, 1955		24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) Collinsville, Illinois	

DATE REC'D BY LOCAL REG. FEB 16 1955		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Shepard Funeral Home, 1167 Hamilton Ave	
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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 *Etton R. Remelino*.....

Licensed Embalmer No. *421*

P. O. Address *St. Louis*

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.