

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19010**
2414

FILED JUN 22 1955

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 5 days		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city, incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION General Hospital # 1				e. STREET ADDRESS (If rural, give location) 3811 E. 18th			
3. NAME OF DECEASED (Type or Print) a. (First) James			b. (Middle) O.		c. (Last) Turner		4. DATE OF DEATH (Month) (Day) (Year) 6 - 4 - 55
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sept. 13 1871	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 8 Days 22	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Train Man)		10b. KIND OF BUSINESS OR INDUSTRY Union Pacific		11. BIRTHPLACE (City and State or Foreign Country) Savannah, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles Turner			13b. MOTHER'S MAIDEN NAME Ruth (Unknown)		14. NAME OF HUSBAND OR WIFE Gertrude Turner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Gertrude Turner 3811 East 18th St.			
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, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute & chronic pyelo-nephritis ANTECEDENT CAUSES DUE TO (b) Benign prostatic hypertrophy-obstructed DUE TO (c) Acute pulmonary edema & obstruction II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH 10 days
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>5/21/1955</u> , to <u>6/4/1955</u> , that I last saw the deceased alive on <u>6/4/1955</u> , and that death occurred at <u>12:50 AM</u> from the causes and on the date stated above.					
23a. SIGNATURE B.I. Burns (Degree or title) M.D.				23b. ADDRESS 24th and Cherry		23c. DATE SIGNED 6/4/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-6-55		24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		24d. LOCATION (City, town, or county) (State) Kansas City, Jackson, Mo.	
DATE REC'D BY LOCAL REG. 6-4-55		REGISTRAR'S SIGNATURE Neva Minshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mollody M. Kelley Eyles 1800 W. 4th St.			

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 E. Hashkman*

Licensed Embalmer No. *413*

P. O. Address *K.C.M.*

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.