

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

233

State File No.

FILED FEB 14 1956

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 5120 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia, Mo. R. 4. S. 4</u>		c. CITY OR TOWN <u>Columbia</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>60 yrs. +</u>		e. STREET ADDRESS (If rural, give location) <u>Rural R. 7. S. 4</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mollie</u>	b. (Middle) <u>Elizabeth</u>	c. (Last) <u>Turner</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7, 1956</u>
-------------------------------------	--------------------------	------------------------------	-------------------------	---

5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May-14-1861</u>	9. AGE (In years last birthday) <u>94</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 WKS. Hours _____ Min. _____
----------------------	-------------------------------	---	-------------------------------------	---	--	---

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 <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Boone Mo. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>Frank Richardson</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Edward Turner</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Amber Turner</u>	ADDRESS <u>Columbia 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		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage -</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis -</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>331x</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) (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 Columbia, Mo., 1956, that I last saw the deceased alive on Feb 11, 1956, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Amber Turner</u>	23b. ADDRESS <u>Columbia, Mo</u>	23c. DATE SIGNED <u>2/8/56</u>
--	----------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb 11-1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Rock Bridge</u>	24d. LOCATION (City, town, or county) (State) <u>Boone Co. Mo.</u>
---	------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>Feb 10 1956</u>	REGISTRAR'S SIGNATURE <u>Mrs R. E. Palmer 31-0</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Stuart P. Parker</u>	ADDRESS <u>Columbia 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 *Stewart D. Parker*.....

Licensed Embalmer No. *290*

P. O. Address *Columbiana*

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.