

FILED APR 23 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12993

STATE FILE NUMBER

5787-56 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 359

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>950 S. Weller</b>		Length of stay in lb <b>Life</b>	d. STREET ADDRESS <b>950 S. Weller</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Daniel</b> First <b>Edward</b> Middle <b>Turner</b> Last			4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 24 1956</b>	9. AGE (In years last birthday) <b>2</b> Months <b>10</b> Days	IF UNDER 1 YEAR Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Springfield, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Glenn O. Turner</b>			14. MOTHER'S MAIDEN NAME <b>Frances L. Scarborough</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Dr. Glenn O. Turner</b> Address <b>Springfield, Mo</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Adrenal Insufficiency</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Less than 1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Acute Nasopharyngitis</b>			<b>1 wk.</b>
		DUE TO (c) <b>Acute Laryngitis</b>			<b>1 wk.</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year <b>p. m.</b>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>Birth</b> to <b>4-13-56</b> and last saw <b>him</b> alive on <b>4-13-56</b> Death occurred at <b>4-13-56 6 A m</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>E. J. Schwartz, M.D.</b> (Degree or title)		22b. ADDRESS <b>609 Cherry Springfield Mo</b>		22c. DATE SIGNED <b>4-16-56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/14/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>		
24. FUNERAL DIRECTOR <b>H. H. Lohmeyer</b> ADDRESS <b>Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-17-56</b>		26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

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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  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Lucian T. Swallow*  
.....

Licensed Embalmer No. *40*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.