

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>4848</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St Louis</b>		c. LENGTH OF STAY (in this place) <b>10 Months</b>		c. CITY OR TOWN <b>St Louis</b>		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 <b>3327 St Vincent St</b>				e. STREET ADDRESS (If rural, give location) <b>3327 St Vincent St</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Robert</b>		b. (Middle) _____		c. (Last) <b>Turner</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 18 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 20, 1861</b>		9. AGE (In years last birthday) <b>94</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Fulton Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah Turner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Patricia Bugh 3327 St Vincent St</b>			
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>FRACTURE, LEFT HIP</b>  ANTECEDENT CAUSES Morbid conditions, if any, rising to the above cause (e.g. dating 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. <b>GENERALIZED ARTERIO SCLEROSIS SACRAL DECUBITUS TERMINAL PNEUMONIA</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 MONTHS</b>  <b>INLET 5 MONTHS LUNGEA</b>	
19a. DATE OF OPERATION <b>SEPT. 1955</b>		19b. MAJOR FINDINGS OF OPERATION <b>INSERTION PINS, LEFT HIP . E 904.0</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) <del>suicide</del> <b>ACCIDENT</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>		21c. (CITY, TOWN, OR TOWNSHIP) <b>3327 ST VINCENT</b> (COUNTY) <b>ST. LOUIS</b> (STATE) <b>MO</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>SEPT 2 1955 5 PM</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Fall at lecture</b>			
22. I hereby certify that I attended the deceased from <b>11 OCT, 1955</b> to <b>1 MAY, 1956</b> , that I last saw the deceased alive on <b>22 APRIL 1956</b> , and that death occurred at <b>6:50 PM</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Clara A. May MD</b>				23b. ADDRESS <b>567 N. S. Rd UNIV CITY</b>		23c. DATE SIGNED <b>5/19/56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>5-19-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		24d. LOCATION (City, town, or county) (State) <b>Desoto Kansas</b>	
DATE REC'D BY LOCAL REG. <b>MAY 19 1956</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington Bl</b>			

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

*John J. Haines*

Licensed Embalmer No. ....

P. O. Address .....

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.