

FILED JUN 20 1956

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22615**

BIRTH NO. _____ REG. DIST. NO. **366** PRIMARY REG. DIST. NO. **6238** Registrar's No. **45**

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY Washington	
b. CITY OR TOWN Belgrade		c. CITY OR TOWN Belgrade	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 309am		e. STREET ADDRESS (If rural, give location) 1100	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) Sarah Jane Turner	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH June 15-56
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Nov. 16 1864	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR Months 6 Days 29	IF UNDER 48 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not employed	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) Jefferson Co. Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Silas Johnson	13b. MOTHER'S MAIDEN NAME Sarah Gates	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Grace McNabb	ADDRESS Belgrade Mo
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Valvular heart lesion		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Influenza Virus pneumonia		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	4214
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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)
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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?
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22. I hereby certify that I attended the deceased from **April 4, 1956**, to **June 15, 1956**, that I last saw the deceased alive on **June 10, 1956**, and that death occurred at **6:45 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph L. Thurman M.D.	23b. ADDRESS 121 E. High - Potosi, Mo.	23c. DATE SIGNED 6-16-1956
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-17-56	24c. NAME OF CEMETERY OR CREMATORY Sunlight Cem.	24d. LOCATION (City, town, or county) (State) Washington Co. Mo
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DATE REC'D BY LOCAL REG. 6/16/56	REGISTRAR'S SIGNATURE Arburt Eudal	25. FUNERAL DIRECTOR'S SIGNATURE Ms. Luther Spahr	ADDRESS Potosi Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

403

RECEIVED

JUN 19

WASH. COUNTY HEALTH DEPT.

FILE NO. _____

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 *Murphy Sparks*

Licensed Embalmer No. *6234*

P. O. Address *Had River, Va.*

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.