

Health, Welfare and Public Service

300 1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1844

STATE FILE NUMBER

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>LAWRENCE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAWRENCE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>AURORA</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>AURORA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>125 COFIELD ST</u>			Length of stay in lb <u>1 YR.</u>	d. STREET ADDRESS (If outside, give location) <u>125 COFIELD ST.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BILLIE</u> Middle <u>COLLEEN</u> Last <u>TURNER</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>1</u> Year <u>1957</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 7, 1955</u>		9. AGE (In years last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>AURORA, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>CHARLES C. TURNER</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA M. DAVIS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHARLES C. TURNER</u>		Address <u>AURORA, Mo</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subfoacation</u> DUE TO (b) <u>First, Second and Third Degree</u> DUE TO (c) <u>burns</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>16</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9160</u>	
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.) <u>trapped inside a burning house</u>					
20c. TIME OF INJURY Hour <u>055</u> Month, Day, Year			20d. INJURY OCCURRED WHILE AT WORK <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 <u>055</u>
20g. COUNTY	STATE	21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>about 10 A.m</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Edwin Wilks</u> (Degree or title) <u>(Coroner)</u>			22b. ADDRESS <u>Piera Ct. Mo.</u>			22c. DATE SIGNED <u>2/1/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>FEB 4, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN</u>		23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, Missouri</u>			
24. FUNERAL DIRECTOR <u>HERMAN LOHMEYER</u>			ADDRESS <u>F.H. Sp5g-Mo</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 2, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Ora Me Natt</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 D. Crafton*

Licensed Embalmer No. *46*

P. O. Address *Amelia*

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.