

Health, Welfare, Public Service  
 100-56  
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **3879**

Registration District No. **43** Primary Registration District No. **3007** Registrar's No. **174**

1. PLACE OF DEATH a. COUNTY <b>Butler</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE, <b>Mo.</b> b. COUNTY <b>Butler</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff, Mo.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Poplar Bluff, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0124
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lucy Lee Hosp.</b>			Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>109 Elm St.</b>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Alvin</b> Last <b>Turner</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>6,</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1884</b>		9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Poplar Bluff, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Turner</b>				14. MOTHER'S MAIDEN NAME <b>Eva Reynold s</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>497-05-0791</b>		17. INFORMANT Address <b>Mrs. C.A. Turner, Poplar Bluff, 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>Lobar Pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <b>Coronary Occlusion, Acute.</b>			2 weeks	
			DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>2</b>				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
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		COUNTY STATE	
21. I attended the deceased from <b>1-24-57</b> to <b>2-6-57</b> and last saw <del>him</del> <sup>her</sup> alive on <b>2-6-57</b> Death occurred at <b>1:05 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>W. McPheeters, M. D.</b>				22b. ADDRESS <b>Poplar Bluff, Missouri</b>		22c. DATE SIGNED <b>2-13-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-8-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Poplar Bluff, Mo.</b>		
24. FUNERAL DIRECTOR <b>Frank-Cotrell Poplar Bluff, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>2/16/57</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

RECEIVED

FEB 18 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

1957 FEB 18 1957

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 *Francis W. Hill*

Licensed Embalmer No. *500*

P. O. Address *Proctor Bluff*

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.