

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8374

STATE FILE NUMBER

FILED APR 1 - 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 264-C

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield <u>03960</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 Burge <u>0</u>		Length of stay in lb 17 months	d. STREET ADDRESS 2040 N. Hoffman (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNE Middle KIMBERLEY Last TURNER			4. DATE OF DEATH Month March Day 19 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1955	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (City and state or country) Springfield, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Turner			14. MOTHER'S MAIDEN NAME Deceased		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Robert Turner Address 2040 N. Hoffman		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidural and subdural hemorrhage.					INTERVAL BETWEEN ONSET AND DEATH 8 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Contusion of cerebral tissue right side head injury					
DUE TO (c) Falling 2 1/2 feet, striking head on floor.					
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Convulsions, shock.					19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) Fell 2 1/2 feet from clothes hanger and struck head on floor			
20c. TIME OF INJURY Hour 3 Month 18 Day 57 p. m. 19-57					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 133		20f. CITY, TOWN, OR LOCATION Springfield, Greene, Mo.	
21. I attended the deceased from 3-18-57 to March 19, 1957 and last saw her alive on 3-19-57 Death occurred at 1:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) David W. Thompson MD			22b. ADDRESS 1630 N Jefferson		22c. DATE SIGNED 3-25-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 21, 1957	23c. NAME OF CEMETERY OR CREMATORY Brookline Cemetery		23d. LOCATION (City, town, or county) (State) Greene County, Missouri
24. FUNERAL DIRECTOR Ralph Thieme		ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 3-27-57	26. REGISTRAR'S SIGNATURE Paula Williams

(Licensed Embalmer's Statement on Reverse Side)

path, Welfare public service
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 Doctor, coroner, etc. must use only standard nomenclature in item 18. All symptoms written instead. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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..... *Lee Mason*

Licensed Embalmer No. 456

P. O. Address Springfield

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.