

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 13 1957

STATE FILE NUMBER

Registration District No. 39 Primary Registration District No. 3006 Registrar's No. 162

Health & Welfare  
Public Service

S. 300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Columbia</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Columbia</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone Co. Hospital</u>		Length of stay in lb <u>Lifetime</u>		d. STREET ADDRESS (If outside, give location) <u>Route 6</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>SAMUEL</u> Last <u>TURNER</u>			4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1875</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Boone County, Missouri.</u>	
13. FATHER'S NAME <u>Samuel D. Turner</u>			14. MOTHER'S MAIDEN NAME <u>Pauline Frances Tucker</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs. Robert S. Turner, Route 6, Columbia, 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>Massive gastro-intestinal hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cause unknown</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>578x</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 Hours</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.)		
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 <u>1 Nov 56</u> to <u>6 May 57</u> and last saw <u>him</u> alive on <u>6 May 57</u> Death occurred at <u>9:20</u> <u>19</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John J. Logue MD</u> (Degree or title)			22b. ADDRESS <u>909 Howard St Columbia Mo</u>		22c. DATE SIGNED <u>6 May 57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 8, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Parker Funeral Service, Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>May 8 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

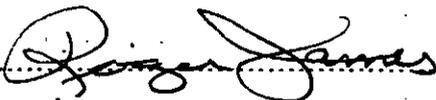
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JUL 10 1959

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  .....

Licensed Embalmer No. 501

P. O. Address Columbia

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.