No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 12 1957

State File No. 25403

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 279

1. PLACE OF DEATH
a. COUNTY: MARION
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): HANNIBAL
c. LENGTH OF STAY (in this place): 9 WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Elizabeth Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: RALLS
c. CITY OR TOWN: NEW LONDON
d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐
STREET ADDRESS (If rural, give location): .087

3. NAME OF DECEASED (Type or Print)
a. (First): SYLVESTER
b. (Middle):
c. (Last): TURNER

4. DATE OF DEATH (Month) (Day) (Year): JULY 29 1957

5. SEX: M
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: OCT 22 1896
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Ralls Co. Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: OSCAR TURNER
13b. MOTHER'S MAIDEN NAME: MAMIE ADAMS
14. NAME OF HUSBAND OR WIFE: ELIZABETH SAYER TURNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 489-42-2470
17. INFORMANT'S SIGNATURE OR NAME: Mrs. A. V. Beavers Frankford Mo. ADDRESS

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

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congestive Heart Failure	7 mths
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	7 mths
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Benigne Hypertrophy Prostate & Cystitis	7 mths

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4200
20. AUTOPSY? YES ☒ NO ☐

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-17-57, 19__, *to* 7-29-57, 19__, *that I last saw the deceased alive on* 7-29-57, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: 100 N. Sixth Hannibal, Mo.
23c. DATE SIGNED: 7-30-57

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 31-1957
24c. NAME OF CEMETERY OR CREMATORY: Salem Baptist Church Cem. (B.R)
24d. LOCATION (City, town, or county) (State): Ralls Co. Mo.

DATE REC'D BY LOCAL REG.: 7/30/57
REGISTRAR'S SIGNATURE: Dr. E. M. Lucke By W. C. Fisher
25. FUNERAL DIRECTOR'S SIGNATURE: J. E. Megown Frankford Mo. ADDRESS
(Licensed Embalmer's Statement on Reverse Side) Fields-Megown Fun. Home

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED AUG 9 1957
MARION CO. HEALTH DEPT.
DATE FILED AUG 9 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Jone Fields Mega

Licensed Embalmer No. 40

P. O. Address Frankford

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai 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.