

FILED SEP 9 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57-0-27495  
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 313

|  |                                  |   |  |   |   |  |  |  |
|--|----------------------------------|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Monroe</u> |   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Columbia</u>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | c. CITY OR TOWN <u>Stoutsville</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer Center</u>  |                                  |   | Length of stay in 1b<br><u>1 da</u>  | d. STREET ADDRESS (If outside, give location)<br><u>R.F.D. #2</u>   |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>Glenn</u> Last <u>Turner</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>31</u> Year <u>1957</u>   |   |  |  |  |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>9-24-1915</u>  |   | 9. AGE (In years last birthday)<br><u>41</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Mins _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Construction Worker</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Aldridge Const. Co.</u>   |  | 11. BIRTHPLACE (City and state or country)<br><u>Monroe City</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |  |
| 13. FATHER'S NAME<br><u>Burris Turner</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Beulah Dodd Turner</u>   |   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>499-05-7928</u>   |  | 17. INFORMANT<br><u>Hospital Records - Highway 40 + 9th</u>   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute lymphatic leukemia</u>   |                                  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |                                  |   |  |   |   |  | DUE TO (b) _____   |  |
| DUE TO (c) _____   |                                  |   |  |   |   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>2040</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<br>Hour _____ Month _____ Day _____ Year _____<br>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>8-30-57</u> to <u>8-31-57</u> and last saw <sup>her</sup> him alive on <u>8-31-57</u><br>Death occurred at <u>11:53</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |   |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>Patrick W. Butler M.D.</u>  |                                  |   |  | 22b. ADDRESS<br><u>Ellis Fischel Cancer Hosp.</u>   |   | 22c. DATE SIGNED<br><u>8-31-57</u>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City, town, or county) (State) |  |  |  |
| <u>Burial</u>  |                                  | <u>Sept 1 1957</u>  |  |   | <u>Parry Mo</u>                               |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Clyde C. Wilkey</u>   |                                  | ADDRESS<br><u>Parry Mo</u>  |  | 25. DATE RECD. BY LOCAL REG.<br><u>Sept 1 1957</u>  |   | 26. REGISTRAR'S SIGNATURE<br><u>Mrs R E Palmer</u>                                   |  |  |

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

SEP 21 1957

SEP 21 1957

SEP 26 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 *Clyde C. Welker*

Licensed Embalmer No. 382

P. O. Address *Perry*

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.