

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 23 1957

State File No. **28432**
Registrar's No. **352**

BIRTH NO. _____		REG. DIST. NO. 146		PRIMARY REG. DIST. NO. 3026		Registrar's No. 352	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence		c. LENGTH OF STAY (in this place) 2 yrs		c. CITY OR TOWN Independence		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 430 E. Kansas St.,				e. STREET ADDRESS (If rural, give location) 430 E. Kansas St., 7200			
3. NAME OF DECEASED (Type or Print) a. (First) EDITH EDIETH			b. (Middle)		c. (Last) TURNER		4. DATE OF DEATH (Month) (Day) (Year) Aug. 6, 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 1, 1884		9. AGE (In years) (Month) (Day) (Year) 73 1 5	IF UNDER 1 YEAR Hours Min.	IF UNDER 4 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Climax Springs, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Zephniah Warren		13b. MOTHER'S MAIDEN NAME Annie Moulder		14. NAME OF HUSBAND OR WIFE Theophilus Turner (decd)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no XXXX		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Agnes McLoes, Independence, Missouri			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac Decompensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arteriosclerotic Heart Disease 10 yrs DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 day	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4200				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/27, 1957 , to 8-6, 1957 , that I last saw the deceased alive on 8-5, 1957 , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) David J. Zimmerman MD				23b. ADDRESS 3005. Liberty - Indep Mo		23c. DATE SIGNED 8/8/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 9, 1957	24c. NAME OF CEMETERY OR CREMATORY Concord Cemetery		24d. LOCATION (City, town, or county) (State) Bates City, Missouri		
DATE REC'D BY LOCAL REG. 8-9-57		REGISTRAR'S SIGNATURE Gene Kray		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Canaday & Ropp, Holden, Missouri.			

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

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Name of Deceased _____
 Date of Death _____
 Place of Death _____
 Sex _____
 Race _____
 Color _____
 Occupation _____
 Cause of Death _____
 Age at Death _____
 Marital Status _____
 Education _____
 Religion _____
 Social Security No. _____
 License No. _____
 State of Issuance _____
 Date of Issuance _____
 Date of Expiration _____
 Signature of Licensed Embalmer _____
 Title _____
 Address _____
 City _____
 State _____
 Zip _____

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 *M. J. Canada*

Licensed Embalmer No. 3434

P. O. Address Holden, Miss

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.