

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29061

STATE FILE NUMBER

FILED SEP 3 1957

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 2021

Health, Welfare, Public Service
000-56
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
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY RANDOLPH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY RANDOLPH	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MOBERLY		c. CITY OR TOWN MOBERLY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WOODLAND HOSP.		d. STREET ADDRESS 1006 W. Rollins	
3. NAME OF DECEASED (Type or print) THOMAS HALL TURNER		4. DATE OF DEATH AUG. 17, 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY Clothing Store	11. BIRTHPLACE (City and state or country) BOONE COUNTY
13. FATHER'S NAME VIRGIL TURNER		14. MOTHER'S MAIDEN NAME MARY KEENE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 491-07-0232	17. INFORMANT Address MRS. T. H. TURNER
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction			INTERVAL BETWEEN ONSET AND DEATH 2 Wks.
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) Acute cholecystitis & stones.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ 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 12 Aug. 1957 to 17 Aug. 1957 and last saw ^{her} _{him} alive on 17 Aug. 1957 Death occurred at 8 am on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Leah Blower M.D. (Degree or title)	22b. ADDRESS 346 Woodland	22c. DATE SIGNED 8/18/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8-19-1957	23c. NAME OF CEMETERY OR CREMATORY OAKLAND	23d. LOCATION (City, town, or county) (State) MOBERLY, Mo.
24. FUNERAL DIRECTOR Address MAHAN FUNIL SERVICE - MOBERLY	25. DATE RECD. BY LOCAL REG. 8-19-57	26. REGISTRAR'S SIGNATURE Leah Blower	

APR 18 1938

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 *John A. Green*

Licensed Embalmer No. *38*

P. O. Address *Moberly*

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.