

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30110

FILED AUG 26 1957

318

1003

STATE FILE NUMBER

6930

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS 2141 Dickson	

3. NAME OF DECEASED (Type or print) Thomas Turner			4. DATE OF DEATH Month 7 Day 21 Year 57		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-1895		9. AGE (In years last birthday) 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Pete Turner			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Address Sarah Turner 2141 Dickson Apt. 206		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Malnutrition		INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ulcerative Colitis		
DUE TO (c) 572.2		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchiectasis - Lung Abscess, Chronic		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year			
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 6-15-57 to 7-21-57 and last saw him alive on 7-21-57
Death occurred at 3:05 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Frank O. Richards, M.D.
22b. ADDRESS 2601 Whittier Street
22c. DATE SIGNED 7-23-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-26-57	23c. NAME OF CEMETERY OR CREMATORY Frierson Cemetery	23d. LOCATION (City, town, or county) (State) Columbus, Mississippi
24. FUNERAL DIRECTOR ADDRESS Ellis Funeral Home 2820 Stoddard St.		25. DATE RECD. BY LOCAL REG. Jul 24 57	26. REGISTRAR'S SIGNATURE Carl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be carefully related. Coroner's name must be carefully related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed..... *F. E. Cull*

Licensed Embalmer No. *41*

P. O. Address *St. Louis*

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.