

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36195

STATE FILE NUMBER

FILED NOV 14 1957

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

4939

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> 548
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LANESIDE HOSPITAL</b>		Length of stay in lb <b>32 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>3309 OLIVE STREET</b>
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>M.</b> Last <b>TURNERY</b>			4. DATE OF DEATH Month <b>OCT.</b> Day <b>22.</b> Year <b>1957</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 27. 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	9. AGE (In years last birthday) <b>77</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>DEKALB COUNTY, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>ABRAM GREGORY</b>		13b. MOTHER'S MAIDEN NAME <b>CAROLINE BURT</b>	14. NAME OF HUSBAND OR WIFE <b>MILTON TURNERY</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>NORVILLE G. WINGATE</b> Address <b>1412 JEWELL TOPERA, KANSAS</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24h.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Esophageal &amp; Gastric Varices</b>			<b>6 wks. ?</b>
DUE TO (c) <b>Portal cirrhosis</b>			<b>10 yrs. ?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Congestive Heart Failure</b>			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"/>		20. 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. 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 <b>10/6 - 57</b> , to <b>10/22. 57</b> and last saw her alive on <b>10/22 - 57</b> Death occurred at <b>9:25 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Elias E. Zintl D.O.</b> (Degree or title)		22b. ADDRESS <b>4640 Troost</b>	22c. DATE SIGNED <b>10/23/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT. 24. 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>		ADDRESS <b>331 BRUSH CAFE KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>10-24-57</b>
			26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Elias E. Zintl

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.



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 *Chester K. Brown*

Licensed Embalmer No. *4931*  
P. O. Address *C. C. Mo.*

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.