

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40022

STATE FILE NUMBER

FILED DEC 2 - 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1132

S. 300  
v. 1-57 0

1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Greene</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u> <u>0346</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's</u>		Length of stay in lb <u>3 hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>st. John's Hospital</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>KAREN</u> Middle <u>FAY</u> Last <u>TURNER</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>21,</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1957</u>	9. AGE (In years last birthday) <u>(3 hours)</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (City and state or country) <u>Springfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Tylman Turner</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Richardson</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Tylman Turner Springfield, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</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)				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.) <u>7620</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <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>Nov. 21, 1957</u> and last saw her alive on <u>AT birth</u> Death occurred at <u>10:15</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Thy Jeth M.D.</u>		22b. ADDRESS <u>1715 BOONVILLE SPRINGFIELD MISSOURI</u>		22c. DATE SIGNED <u>11-27-57</u>	
23a. BURIAL, CREMATION, etc. (If) <u>Burial</u>		23b. DATE <u>Nov. 23, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Eastlawn</u>	
		23d. LOCATION (City, town, or county) <u>Springfield,</u>		(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Ralph Thieme</u> ADDRESS <u>Springfield, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>11-29-57</u>		26. REGISTRAR'S SIGNATURE <u>Edith Williams</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Lee Mason* .....

No (arterial injection)

Licensed Embalmer No. 4568 .....

P. O. Address Springfield, 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.