FILED JAN 27 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3881
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 125

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON MO — Inside Limits Yes ✓ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) COUNTY HOSPITAL — Length of stay in 1b 6 days

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST LOUIS
c. CITY OR TOWN ROCKHILL MO 46310 — Inside Limits Yes ✓ No ☐
d. STREET ADDRESS (If outside, give location) 219 EUCLID AVE — Reside on Farm Yes ☐ No ✓

3. NAME OF DECEASED (Type or print) First Frank Middle Last Turner
4. DATE OF DEATH Month 1 Day 10 Year 58
5. SEX MALE
6. COLOR OR RACE NEGRO
7. MARRIED ✓ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH DEC 25 1881
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY YARDWORK
11. BIRTHPLACE (City and state or country) YELLOW BUSH COUNTY MISS
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME NAPOLEON TURNER
14. MOTHER'S MAIDEN NAME ELLEN WINTERS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Evalene Turner Address 219 Euclid Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c) 331X
INTERVAL BETWEEN ONSET AND DEATH
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 ✓ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1-4-58, to 1-10-58 and last saw her/him alive on 1-10-58
Death occurred at 9:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jesse Th. Page, MD
22b. ADDRESS 601 So. Brentwood
22c. DATE SIGNED 1-11-58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 1-18-58
23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON
23d. LOCATION (City, town, or county) (State) CRESTWOOD MO

24. FUNERAL DIRECTOR ADDRESS F. T. Yandell & Sons 197 E. Kirkham Webster Groves Mo
25. DATE RECD. BY LOCAL REG. 1-14-1958
26. REGISTRAR'S SIGNATURE Herbert R Domke MD

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Theodore J. Gana

Licensed Embalmer No. 42

P. O. Address 1306 Ld
Webster Groves

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.