

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018687  
STATE FILE NUMBER

FILED JUN 5 1958 Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 107

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>Ray</b>					
b. CITY (If outside Corporate Limits, give TOWNSHIP only) OR TOWN <b>Rural Prairie</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Orrick</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4 Cedarcroft Nursing</b>			Length of stay in lb <b>4 1/2 Yrs.</b>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Isom</b> Middle <b>Turner</b> Last <b>Turner</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1958</b>					
5. SEX <b>Male</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>Sept. 22, 1866</b>		9. AGE (In years last birthday) <b>91</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Orrick, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Calvin Turner</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Clevenger</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>497-24-9346</b>		17. INFORMANT <b>Eugene Turner 455 W. Dartmouth K.S. Mo.</b>			Address	
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>Arterio Sclerotic Heart Disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Generalized arterio-sclerosis</b> DUE TO (c) <b>42.00</b>								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 <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 <b>1:00</b> Month, Day, Year <b>May 13, 1958</b> a. m. <b>a</b> 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 <b>Orrick</b>		COUNTY <b>Missouri</b>		STATE	
21. I attended the deceased from <b>Jan 1956</b> to <b>May 13, 1958</b> and last saw <sup>her</sup> him alive on <b>5-13-58</b> Death occurred at <b>1:00</b> <b>a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Philip Haper M.D.</b> (Degree or title)				22b. ADDRESS <b>Keis Summit Mo</b>				22c. DATE SIGNED <b>5-13-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 14, 1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SouthPoint</b>		23d. LOCATION (City, town, or county) (State) <b>Orrick Missouri</b>			
24. FUNERAL DIRECTOR <b>Wilbur G. Cole Orrick Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>May 13-1958</b>		26. REGISTRAR'S SIGNATURE <b>N. B. Langford</b>			

Health, Welfare Public Service

300 1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUN 3 1958

**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 *John Pasley*

Licensed Embalmer No. 430

P. O. Address *Liberty, Mo*

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.