

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035469

STATE FILE NUMBER

FILED NOV 3 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 274

5. 300
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1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Regersville MO</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hofano Medical Center Soda</u> Length of stay in 1b		1120 STREET ADDRESS <u>Route 3</u> (If outside, give location) Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael Allen Turney</u>			4. DATE OF DEATH Month Day Year <u>10 23 1958</u>
5. SEX <u>Male</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>8-31-50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE (In years last birthday) <u>8 yr 2 mo.</u> FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>? OREGON.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>THOMAS TURNERY</u>		13b. MOTHER'S MAIDEN NAME <u>Georgia L. ---</u>	14. NAME OF HUSBAND OR WIFE <u>---</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT Address <u>Medical Chart</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 Edema; CHRONIC CONGESTIVE FAILURE</u> DUE TO (b) <u>Aortic INSUFFICIENCY. & possibly</u> DUE TO (c) <u>Aortic stenosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Had aortic valvulotomy in 6/27/58 for congenital aortic stenosis 7545</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8/5/58 to 10/23/58</u> <u>Presently apnoeic</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m.		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>10/16/58</u> to <u>10/23/58</u> and last saw her alive on <u>10/23/58</u> Death occurred at <u>125 PM 10/23/58</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Helen M. Waiches M.D.</u>		22b. ADDRESS <u>Columbia Missouri Dept. of Peds, University of Missouri</u>	
22c. DATE SIGNED <u>10/23/58</u>		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10/26/58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WEBSTER CO. MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Robert Bergman, Lebanon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 25 1958</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>			

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Max L Miller*

Licensed Embalmer No. *4720*

P. O. Address *Mansfield*

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.