

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047171
STATE FILE NUMBER
149 Primary Registration District No. 1002 Registrar's No. 6239

FILED JAN 19 1959

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-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hosp.		Length of stay in 1b 7 yrs	d. STREET ADDRESS (If outside, give location) 8840 Virginia Lane
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Edith Middle I. Last Turner			4. DATE OF DEATH Month December Day 31, Year 1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1878	9. AGE (In years last birthday) 80	10. F UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Deep River, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Pine	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE Roscoe Turner
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT Leland R. Turner, 8840 Virginia Lane, Mo. Address K.C.
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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>Cerebral Vascular Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Thrombocytopenia</u>	
	DUE TO (c) <u>Chronic Myelogenous Leukemia</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2041</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. 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 COUNTY STATE
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21. I attended the deceased from Death occurred at <u>4-27-58</u> to <u>12-31-58</u> and last saw her alive on <u>12-31-58</u> <u>9A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>R. K. Skillman MD</u> (Degree or title) 0	22b. ADDRESS <u>4635 Wyandotte K.C. Mo</u>	22c. DATE SIGNED <u>12-31-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan 1, 1959	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Anita, Iowa.
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24. FUNERAL DIRECTOR Mellody-McGilley-Eylar, 205 W. Linwood K. C. Mo.	25. DATE RECD. BY LOCAL REG. 12-31-58	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 R. K. Skillman

Dr. Skillman
1635 W. 35th St.

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 *W. H. Denty*
Licensed Embalmer No. *5038*
P. O. Address *K. 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.