

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000884
STATE FILE NUMBER

FILED FEB 9 1959

Registration District No. 115-116 Primary Registration District No. 5434 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. John's Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Washington</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>Washington R.W.</u> Length of stay in 1b <u>10 mo.</u>		d. STREET ADDRESS (If outside, give location) <u>R.W., Box 56</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Horace Leo Turner</u>			4. DATE OF DEATH Month Day Year <u>Feb. 5, 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1890</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Month Days <u>6 9</u>	IF UNDER 24 HRS. Hours Min. <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transport Truck</u>	11. BIRTHPLACE (City and state or country) <u>Wisconsin</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mary M. Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give vol or dates of service) <u>yes W.W. I</u>		16. SOCIAL SECURITY NO. <u>331-12-1990A</u>	17. INFORMANT Address <u>R.W. Box 56</u> <u>Mary M. Turner, Washington, Missouri</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>Carcinoma of Mediastinum</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of left lung</u>			18. INTERVAL BETWEEN ONSET AND DEATH <u>W. Edmund</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>163X</u>			
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 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	
21. I attended the deceased from <u>Dec 8, 1958</u> to <u>Feb 5, 1959</u> and last saw her alive on <u>Feb 3, 1959</u> Death occurred at <u>8:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>F. O. Muench - M.D.</u>		22b. ADDRESS <u>208th Washington Mo.</u>	
22c. DATE SIGNED <u>1-6-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal Feb. 6, 1959</u>		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY <u>Wilwood Cemetery, Rockford, Illinois</u>		23d. LOCATION (City, town, or county) (State) <u>Rockford, Illinois</u>	
24. FUNERAL DIRECTOR <u>Nieburg & Witt, Inc., Washington Mo.</u> <u>L. H. Witt</u>		25. DATE RECD. BY LOCAL REG. <u>2/6/59</u>	
26. REGISTRAR'S SIGNATURE <u>F. J. Ludman & L. H. Witt</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

FEE 24 1959

MAR 3 1959

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 *Lester H. Witt*

Licensed Embalmer No. *3254*
P. O. Address *Washington, D.C.*

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.