

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007731

STATE FILE NUMBER

2 1318

Health,  
Welfare  
Public  
Service

300  
-57  
292  
0

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2 1318**

**FILED FEB 17 1959**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6622 MACKLIND</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>6622 MACKLIND</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH W. TURNER</b>			4. DATE OF DEATH Month Day Year <b>FEB. 5 1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 14 1901</b>
9. AGE (In years last birthday) <b>57</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FALSTAFF Brewery</b>	11. BIRTHPLACE (City and state or country) <b>Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>WILLIAM TURNER</b>	
13b. MOTHER'S MAIDEN NAME <b>MARY RYNES</b>		14. NAME OF HUSBAND OR WIFE <b>LOUISE TURNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WARE</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT Address <b>LOUISE TURNER 6622 MACKLIND</b>
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>Cardiac Insufficiency</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma (Cancer) of the Colon</b>			<b>6 Months</b>
DUE TO (c) <b>153. B</b>			
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 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 <b>Sept. 3, 1958</b> to <b>Feb. 5th, '59</b> and last saw <sup>him</sup> alive on <b>Feb. 5th, 1959</b> Death occurred at <b>7:30 A. M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>W. T. Walters M.D.</b>		22b. ADDRESS <b>3608 South Grand Blvd.</b>	22c. DATE SIGNED <b>2/6/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>FEB. 7 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>Thomas Hutes 2906 Garvia</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 6 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b>

9-12 am Friday

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 James C. Will

Licensed Embalmer No. 4347  
P. O. Address 29106 Davis

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.