

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012105

STATE FILE NUMBER

FILED MAR 24 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 46

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Vernon | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Newton | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Stark City 0730 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #3 | | Length of stay in 1b 6 yrs. 5 mos. | d. STREET ADDRESS (If outside, give location) Route 1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First John Middle Riley Last Turner | | | 4. DATE OF DEATH Month 3 Day 18 Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-12-1881 |
| 9. AGE (In years last birthday) 75 | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (City and state or country) Stark City, Missouri |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME Unknown | |
| 13b. MOTHER'S MAIDEN NAME Mary Carter | | 14. NAME OF HUSBAND OR WIFE Sarah Turner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Address Hospital Records State Hospital #3, Nevada |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Coma | | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized Arteriosclerosis | | | Years |
| DUE TO (c) _____ | | | |
| 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 10-2-1952 to 3-18-1959 and last saw ^{her} him alive on 3-18-1959 Death occurred at 9:50 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>George Oster M.D.</i> (Degree or title) | | 22b. ADDRESS State Hospital #3, Nevada, Mo. | 22c. DATE SIGNED 3/18/1959 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 3-22-1959 | 23c. NAME OF CEMETERY OR CREMATORY Dice Cemetery | 23d. LOCATION (City, town, or county) (State) Fairview, Missouri |
| 24. FUNERAL DIRECTOR Floyd E. Shewmake Jr. Granby, | | 25. DATE RECD. BY LOCAL REG. 3-21-1959 | 26. REGISTRAR'S SIGNATURE <i>Anna J. Jerry</i> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Floyd E. Skumake, Jr.*

Licensed Embalmer No. *4923*
P. O. Address *Box 58 Danby, Me.*

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.