

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013018

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 385

FILED APR 20 1959

300
-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If outside, give location) 801 E. Adams	
3. NAME OF DECEASED (Type or print) Betty Jo Turner		4. DATE OF DEATH Month April Day 11 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Springfield, Missouri
13a. FATHER'S NAME W. T. Turner		13b. MOTHER'S MAIDEN NAME Sherley Kelly	14. NAME OF HUSBAND OR WIFE None
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. No	17. INFORMANT Address Hospital Records
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>Respiratory Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Convulsions</u> DUE TO (c) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
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 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 a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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>4/8/59</u> to <u>4/11/59</u> and last saw her alive on <u>4/10/59</u> Death occurred at <u>12:45</u> a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS 609 Cherry Springfield, Mo.	
22c. DATE SIGNED <u>4/11/59</u>			
23a. BURIAL, CREMATION, REBURYAL (Specify) Burial	23b. DATE 4-13-1959	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Greene Mo.
24. FUNERAL DIRECTOR J.W. KLINGNER & CO. SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 4-15-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ogle Stone Jr.*

Licensed Embalmer No. *4176*
P. O. Address *Springfield*

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.