

Dr. Elkins

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013019

STATE FILE NUMBER

DEAD APR 27 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 416

5. 300
1-57

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD 0.396	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 610 STATE		d. STREET ADDRESS (If outside, give location) 610 STATE	
Length of stay in lb 76 YRS.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARVE W. TURNER			4. DATE OF DEATH Month Day Year APRIL 22 1959
5. SEX MALE 0	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 JAN. 22 1883
9. AGE (In years last birthday) 76		10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED POWELL BROS TRUCK LINES		11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO. 0	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME C.C. TURNER		13b. MOTHER'S MAIDEN NAME SARAH GAULT	
14. NAME OF HUSBAND OR WIFE LAVRA TURNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 491-03-0114	
17. INFORMANT Address MRS. LAVRA TURNER SPRINGFIELD, MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - acute Coronary Heart Disease. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4201
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 Springfield, MO		20g. COUNTY STATE	
21. I attended the deceased from April 22 '59 , to _____ and last saw her/him alive on _____ Death occurred at 3 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Ronald F. Elkins M.D.		22b. ADDRESS Springfield, MO	
22c. DATE SIGNED 4-23-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/24/59	
23c. NAME OF CEMETERY OR CREMATORY WHITE CHAPEL		23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.	
24. FUNERAL DIRECTOR H.H. LOHMEYER		ADDRESS SPRINGFIELD, MO.	
25. DATE RECD. BY LOCAL REG. 4-23-59		26. REGISTRAR'S SIGNATURE Effie G. Melton	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *H. L. McCann*

Licensed Embalmer No. *2727*

P. O. Address *Springfield 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.