

BUREAU OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031332

FILED TO AUG 18 1959 **374**

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **30**

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Worth				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Worth			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Grant City		Length of stay in 1b 13 months		c. CITY OR TOWN Sheridan		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grant City Nursing Home				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Arthur Turner				4. DATE OF DEATH Month July Day 28 Year 1959			
5. SEX Male	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 3-17-1885	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer and Dealer			10b. KIND OF BUSINESS OR INDUSTRY Implements		11. BIRTHPLACE (City and state or country) Near Hopkins, Mo.		12. CITIZEN OF WHAT COUNTRY U. S.
13a. FATHER'S NAME Joseph Turner			13b. MOTHER'S MAIDEN NAME Lizie Early			14. NAME OF HUSBAND OR WIFE Never Married	
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. 493-18-5318		17. INFORMANT Address Mrs. Grace Hoxworth-Sheridan, 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) Arteriosclerosis, generalized; Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 3 years 3 months	
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) Amputation rt leg due to above						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m.		Month, Day, Year					
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>1956</u> to <u>July 28, 59</u> and last saw her/him alive on <u>July 28, 59</u> Death occurred at <u>5pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Frank B Matteson M.D.</i> (Degree or title) Frank B Matteson M.D.				22b. ADDRESS Grant C		22c. DATE SIGNED 7/30/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-30-1959	23c. NAME OF CEMETERY OR CREMATORY Sheridan Cemetery			City, Town, or county Sheridan, Missouri	(State)
24. FUNERAL DIRECTOR <i>Bill D. Dunfee</i> ADDRESS Grant City, Mo.				25. DATE RECD. BY LOCAL REG. Aug 15 1959		26. REGISTRAR'S SIGNATURE <i>Dawkins Kibbe</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bill A. Du

Licensed Embalmer No. 490

P. O. Address Grant

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.