

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031735

FILED VS OCT 13 1959 59

Registration District No. _____ Primary Registration District No. 4097 Registrar's No. 152

STATE FILE NUMBER

DEED

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| 1. PLACE OF DEATH a. COUNTY CASS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE Missouri b. COUNTY CASS | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Harrisonville | | Length of stay in lb 5 Days | c. CITY OR TOWN 302 W Mechanic Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) HARRISONVILLE, MO. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First LILLIE Middle FLORENCE Last TURNER | | | 4. DATE OF DEATH Month oct Day 2 Year 1959 | | | |
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|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-4-1878 | 9. AGE (last birthday) 80 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and state or country) ASH GROVE, MO. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME John PARKER | 13b. MOTHER'S MAIDEN NAME VENELIA ELSON | 14. NAME OF HUSBAND OR WIFE LOUIS TURNER |
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| 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. 500-12-1861 | 17. INFORMANT ELIZABETH M'BRIDE, BELTON, MO | Address _____ |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | INTERSTITIAL NEPHRITIS*ARTERIAL HYPERTENSION | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) INTESTINAL VIRUS INFECTION- SENILITY | |
| | DUE TO (c) SYSTEMIC NUTRITIONAL DEFICIENCY | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | 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 |
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| 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.) |
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|---|---|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY Hour _____ 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 |
|---|---|--|------------------------------|--------|-------|

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| 21. I attended the deceased from SEPTEMBER 26 59 to OCTOBER 2 59 and last saw her last saw him alive on OCT 1 1959 |
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Death occurred at **1.05 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>David A. Long, M.D.</i> | 22b. ADDRESS HARRISONVILLE, MO. | 22c. DATE SIGNED OCT 3 59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 10-4-1959 | 23c. NAME OF CEMETERY OR CREMATORY Ash Grove Cemetery | 23d. LOCATION (City, town, or county) (State) Ash Grove, Missouri |
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| 24. FUNERAL DIRECTOR ATKINSON DICKY HARRISONVILLE, MO | 25. DATE RECD. BY LOCAL REG. 10-3-1959 | 26. REGISTRAR'S SIGNATURE <i>Wm Gray Seabee</i> |
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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 Robert Atkinson

Licensed Embalmer No. 4902

P. O. Address Hannover

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.