

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005950

FILED VS MAR 14 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 288

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b		c. CITY OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HANDLEY HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2102 N. Howard</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or sex) <u>MARCUS</u> MA First Middle Last <u>L. TURNER</u>				4. DATE OF DEATH Month Day Year <u>MARCH 5 1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 27, 1874</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Springfield Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>CHRISTOPHER TURNER</u>			13b. MOTHER'S MAIDEN NAME <u>MABLE MARTIN</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>500-05-8081</u>		17. INFORMANT <u>Mr WILLIAM BAKER</u>		Address <u>SPRINGFIELD</u>		
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>Cerebral apoplexy</u>						INTERVAL BETWEEN ONSET AND DEATH		
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)						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 checked="" 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>2/25/60</u> to <u>3/5/60</u> and last saw him alive on <u>3/5/60</u> Death occurred at <u>7:35 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Leman D. Brown M.D.</u>				22b. ADDRESS <u>311 1/2 College</u>		22c. DATE SIGNED <u>3/6/60</u>		
23a. BURIAL, CREMATION, or MOVABLE (Specify) <u>Burial</u>		23b. DATE <u>3-8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eastlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>			
24. FUNERAL DIRECTOR <u>KLINGNER MORTUARY</u>			ADDRESS <u>SPRINGFIELD Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-7-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Meeten</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 *Agla Line*
Licensed Embalmer No. 417

P. O. Address *Spring*

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