

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006778

FILED VS MAR 8 1960

Registration District No. 146 Primary Registration District No. 4237 Registrar's No. 123

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RAYTOWN	a. STATE MISSOURI	b. COUNTY JACKSON
Length of stay in 1b 47 yrs.		c. CITY OR TOWN RAYTOWN	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 8011 SPRINGVALLEY ROAD.		d. STREET ADDRESS (If outside, give location) 8011 SPRINGVALLEY ROAD	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First HERBERT RAY	Middle TURNER	Last	4. DATE OF DEATH	Month FEB	Day 26	Year 1960
-------------------------------------	-----------------------------	-------------------------	------	------------------	---------------------	------------------	---------------------

5. SEX MALE	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 NOV 14, 1895	9. AGE (last birthday) 64 yrs.	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) ENGINEER K. C. GENERAL HOSP.	10b. KIND OF BUSINESS OR INDUSTRY STOUTSVILLE MO.	11. BIRTHPLACE (City and state or country) USA	12. CITIZEN OF WHAT COUNTRY USA
--	---	--	---

13a. FATHER'S NAME CARR TURNER	13b. MOTHER'S MAIDEN NAME DORA B. GATSON	14. NAME OF HUSBAND OR WIFE RUBY G. TURNER
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW1	16. SOCIAL SECURITY NO. 494 14 4557	17. INFORMANT RUBY G. TURNER 8011 SPRINGVALLEY RD.
--	---	--

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) Coronary Arteriosclerosis	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) arteriosclerotic heart disease	
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 checked="" type="checkbox"/> NO <input 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 KANSAS CITY MO.	COUNTY JACKSON	STATE MISSOURI
--	--	--	--------------------------	--------------------------

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____.
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Dr. W. W. Newcomer</i>	22b. ADDRESS <i>602 West 15th St</i>	22c. DATE SIGNED <i>2-28-60</i>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2 29 60	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEM	23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.
--	-----------------------------	---	---

24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS K. C. MO.	25. DATE RECD. BY LOCAL REG. 2-29-60	26a. REGISTRAR'S SIGNATURE <i>James A. Casey</i>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 7 1960

STATEMENT BY LICENSED EMBALMER

MAR 9 1

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 Raymond M. Hardy

Licensed Embalmer No. 4913

P. O. Address Indep, Md

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.