

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS MAR 7 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2 1896** - **60-008996** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>	Length of stay in 1b <b>159 DAYS</b>	c. CITY OR TOWN <b>EAST ST. LOUIS,</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VAH, 915 NO. GRAND AVE.</b>		d. STREET ADDRESS (If outside, give location) <b>4009 PIGGOTT</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>SHELEY</b> Middle <b>B.</b> Last <b>TURNER</b>			4. DATE OF DEATH Month <b>2</b> Day <b>16</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/7/27</b>	9. AGE (last birthday) <b>32</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>E. ST. LOUIS, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>ELVIN TURNER</b>		13b. MOTHER'S MAIDEN NAME <b>ROSETTA BARNES</b>		14. NAME OF HUSBAND OR WIFE <b>ADDIE TURNER</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>	16. SOCIAL SECURITY NO. <b>350-14-3554</b>	17. INFORMANT <b>ADDIE TURNER (WIDOW)</b>	Address <b>4009 PIGGOTT AVE. E. ST. LOUIS, ILL.</b>
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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: IMMEDIATE CAUSE (a) <b>MYASTHENIA GRAVIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____ <b>744.0</b>	

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 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 <b>VAH, ST. LOUIS, MO.</b>	COUNTY _____ STATE _____
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21. **VA** attended the deceased from **9/10/59** to **2/16/60** and last saw ~~her~~ **him** alive on **2/16/60**  
Death occurred at **9:40 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>A. Fritsch</b> <i>A. Fritsch</i>	(Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>2/16/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/23/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Missouri</b>
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24. FUNERAL DIRECTOR <b>Marionde Office</b>	ADDRESS <b>214 Missouri Ave. E. St. Louis, Ill.</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 18 1960</b>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
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(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 Frank Proko pf

Licensed Embalmer No. 4356

P. O. Address St. Louis

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.