JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

LED VS NOV 1 1960

NDED

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 212

-60-038713
STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY Jasper
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage
Length of stay in 1b 24 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Allen
c. CITY OR TOWN Iola
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 327 N. 4th
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ROSE Middle CECILIA Last TURNER
4. DATE OF DEATH Month October Day 26 Year 1960
5. SEX female
6. COLOR OR RACE white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 12-7-1897
9. AGE (last birthday) 62
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) housewife
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (City and state or country) Iola, Kansas
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John Frebig
13b. MOTHER'S MAIDEN NAME Pauline ?
14. NAME OF HUSBAND OR WIFE Fred B. Turner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Fred B. Turner, 327 N 4th, Address Iola, Kansas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH Few Min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Post Traumatic Thrombi — ?
DUE TO (c) Multiple Fractures both lower ext — 25 da
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☒ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Automobile accident
20c. TIME OF INJURY Hour 2:00± p.m. Month, Day, Year 10-2-60
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway
20f. CITY, TOWN, OR LOCATION East of Carthage Mo on H.W. 66 COUNTY STATE

21. I attended the deceased from Oct 7, 60 to Oct 26, 60 and last saw her alive on 10-26-60
Death occurred at 6:04 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B Russell Smith (Degree or title) M.D.
22b. ADDRESS 304 Grant, Carthage, Mo
22c. DATE SIGNED 10-27-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE 10-27-60
23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery
23d. LOCATION (City, town, or county) (State) Iola, Kansas
24. FUNERAL DIRECTOR KNELL MORTUARY ADDRESS Carthage, Mo
25. DATE RECD. BY LOCAL REG. 10-27-60
26. REGISTRAR'S SIGNATURE Ely Clinton

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

NOV 3 1960

FEB 21 1961

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_____ Signed Robert H. Knell

Signature of Student Embalmer

Licensed Embalmer No. 4459

P. O. Address Carthage, Mo

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