

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040322

FILED VS. OCT 19 1960
 REGISTRATION DISTRICT NO. _____

318 Primary Registration District No. 1003

Registrar's No. 9866

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3940 Lafayette Ave.	
3. NAME OF DECEASED (Type or print) First Sarah Middle Louise Last Turner			4. DATE OF DEATH Month 10 Day 10 Year 1960		
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 12/18/68	9. AGE (last birthday) 91 yrs.	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Detroit, Mich.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Unknown Lehman		13b. MOTHER'S MAIDEN NAME Mary Unknown	14. NAME OF HUSBAND OR WIFE John Turner		
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. none	17. INFORMANT Address Lillian Owen 3833 Folsom Ave.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Bronchial Pneumonia
 DUE TO (b) Pulmonary Thrombosis
 DUE TO (c) Severely Atherosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
none

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.)
450.0

20c. TIME OF INJURY
 Hour _____ Month, Day, Year _____
 a.m. _____ p.m. none

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.)
none

21. I attended the deceased from 1950 to 10/10/1960 and last saw her alive on 10/10/60
 Death occurred at 12:55 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Proton C Hall CEO

22b. ADDRESS
3902nd Lafayette

22c. DATE SIGNED
10/11/60

23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

23b. DATE
10/13/60

23c. NAME OF CEMETERY OR CREMATORY
Memorial Park

23d. LOCATION (City, town, or county) (State)
St. Louis Co., Mo.

24. FUNERAL DIRECTOR
E.J. Schnur ADDRESS **3125 Lafayette Ave.**

25. DATE RECD. BY LOCAL REG.
OCT 11 1960

26. REGISTRAR'S SIGNATURE
Loan Smith, M.D.

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
 or by _____, Student Embalmer No. _____
 working under my personal supervision.

Student _____
 Signature of Student Embalmer

Signed Thomas R. Remer

Licensed Embalmer No. 379
 P. O. Address 3125 Ta

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.