

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045451

FILED VS. DEC 29 1960 7/1

STATE FILE NUMBER

INDEXED

Registration District No. 7/1 Primary Registration District No. 2012 Registrar's No. 107

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>	Length of stay in 1b <u>24 years</u>	c. CITY OR TOWN <u>Excelsior Springs</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs Hosp.</u>		d. STREET ADDRESS <u>206 West Excelsior</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna Elizabeth</u> Middle <u>Turner</u> Last <u>Turner</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>9th</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>xxx</u>		11. BIRTHPLACE (City and state or country) <u>Ames, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Sol Cook</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Crouch</u>		14. NAME OF HUSBAND OR WIFE <u>James Turner</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>500-03-2444</u>		17. INFORMANT <u>Otis Cook, Holt St. Ex. Spgs. MO</u>			

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) <u>Coronary occlusion</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic heart disease</u>	
	DUE TO (c) <u>Arteriosclerosis</u>	

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 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 <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>		
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	COUNTY STATE
21. I attended the deceased from <u>1-2-60</u> to <u>9 Nov '60</u> and last saw her alive on <u>9 Nov '60</u> Death occurred at <u>7 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>		22b. ADDRESS <u>Excelsior Springs, Mo</u>		22c. DATE SIGNED <u>11-10-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 11, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, MO.</u>	
24. FUNERAL DIRECTOR <u>Chas. Virgil Hoops, Ex. Spgs. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-2-60</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</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 Chas. Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior

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.