

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004675
STATE FILE NUMBER

AMENDED FILED VS FEB 27 1961
Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 178

DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 60 yrs		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2709 Lafayette St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last FLOYD ERNEST TURLEY				4. DATE OF DEATH Month Day Year February 17 1961									
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 6/19/1890		9. AGE (last birthday) 70		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) Retired Meat Inspector				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (City and state or country) Doniphan Co. Kansas		12. CITIZEN OF WHAT COUNTRY U S A					
13a. FATHER'S NAME Frank Turley				13b. MOTHER'S MAIDEN NAME Sarelda N. Lampkin				14. NAME OF HUSBAND OR WIFE Mrs. Katherine Turley					
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 Mrs. Katherine Turley				Address 2709 Lafayette St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic E myyema, left pleural cavity</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hemorrhage from duodenal ulcer</u>								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 type="checkbox"/> NO <input checked="" 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 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		COUNTY		STATE					
21. I attended the deceased from <u>2/6/61</u> to <u>2/17/61</u> and last saw him alive on <u>2/17/61</u> Death occurred at <u>5:30P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Donald Stallard, M.D.</u>						22b. ADDRESS <u>902 Edmund St.</u>			22c. DATE SIGNED <u>2/18/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>						
24. FUNERAL DIRECTOR <u>Stammy Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Feb. 21, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>							

D. Stallard, M.D. MEDICAL CERTIFICATION

FFR 27 1961

MAR 2 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles E Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph Mo

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.