

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

64-024638
STATE FILE NUMBER

AMENDED

Filed in District ¹⁰⁰ JUL 24 1961 Primary Registration District No. 3018 Registrar's No. 70

1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem, Missouri</u>		Length of stay in lb <u>3yr.</u>		c. CITY OR TOWN <u>Salem, Missouri</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>North Washington St./ Salem, Missouri</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>North Washington St. Salem, Missouri</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>C.</u> Last <u>Turner</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 5, 1880</u>		9. AGE (last birthday) <u>81</u> 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) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (City and state or country) <u>Laclede Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Zackeri Rogerson</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Robinson</u>			14. NAME OF HUSBAND OR WIFE <u>George W. 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>X</u>		17. INFORMANT Address <u>Mrs. Ila Allison, Salem, Mo.</u>				
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>Coronary Arteriosclerosis</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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			
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 _____ 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 COUNTY STATE			
21. I attended the deceased from <u>2-3-58</u> to <u>1961</u> and last saw her/him alive on <u>5-12-61</u> Death occurred at <u>4:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (In degree or title) <u>[Signature]</u>		22b. ADDRESS <u>Salem</u>		22c. DATE SIGNED <u>7/19/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		23b. DATE <u>July 19, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Dallas, County, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>SPENCER FUNERAL HOME INC. SALEM, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>7/19/61</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

JUL 25 1967

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 Carl H. Janner

Licensed Embalmer No. 9374

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.