

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039719

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3132

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		Length of stay in 1b <u>3 days.</u>	c. CITY OR TOWN <u>Kennett</u>
c. FULL NAME OF (If NOT in hospital, give location) <u>St Louis County</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5526 McGuire</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>DIANA MARIE TURNER</u>			4. DATE OF DEATH Month Day Year <u>OCT. 28, 1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-'41</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>2 months 2 19</u>
11. BIRTHPLACE (City and state or country) <u>St Louis, Mo</u>		12. CITIZENSHIP OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Wm. J. Turner</u>		13b. MOTHER'S MAIDEN NAME <u>Bernie Turner</u>	
14. NAME OF HUSBAND OR WIFE —		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		17. INFORMANT —	

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>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Congenital heart disease with</u>	<u>2 months</u>
	DUE TO (c) <u>multiple anomalies.</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 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 OCT. 25, 1961 to OCT. 28, 1961 and last saw her alive on OCT. 28, 1961  
Death occurred at 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. Michael G. M.D.</u> (Degree or title)	22b. ADDRESS <u>601 BRENTWOOD BL. CLAYTON MO</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>11-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Crematory</u>
23d. LOCATION (City, town, or county) <u>St Louis MO</u>	23e. STATE (State)	
24. FUNERAL DIRECTOR <u>County Hosp. Clayton, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-7-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.