

## OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040136

STATE FILE NUMBER

Registration District No. 38Primary Registration District No. 3006Registrar's No. 706

AMENDED

FILED NOV 27 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>7 weeks</u>	c. CITY OR TOWN <u>Columbia</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>Rectors Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1515 Liberty</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>TURNER</u> Last <u>TURNER</u>			4. DATE OF DEATH Month <u>November</u> Day <u>21</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1889</u>
9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u>  </u> Days <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>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Columbia, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Richard J. Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret F. Jerrell</u>
14. NAME OF HUSBAND OR WIFE <u>James W. Turner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> , or unknown) (If yes, give war or dates of service)	17. INFORMANT Address <u>Mrs. Daniel Hall, Columbia, 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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Impaired Circulatory</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10-2061</u> <u>April 6'</u> <u>7</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"/> N <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 <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>April 6'</u> to <u>Nov 21'6'</u> and last saw her <u>live</u> on <u>Nov 21 6'</u> Death occurred at <u>Nov 21' 1961 11:31P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. S. Anderson D.O.</u> (Degree or title)		22b. ADDRESS <u>Columbia Mo</u>	22c. DATE SIGNED <u>11-23-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 25, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Parkers Funeral Service Columbia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov 24, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed George P. Kerby

Licensed Embalmer No. 4752

P. O. Address Columbia, Md.

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.