

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-006742  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 862

AMENDED

**FILED MAR 7 1962**

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>1 yr</u>		c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3323 Wabash</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lucretia</u> Middle <u>Turner</u> Last <u>Turner</u>			4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>62</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>11-24-1891</u>	9. AGE (last birthday) <u>70 yrs</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>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Mississippi</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Peter Weathers</u>		13b. MOTHER'S MAIDEN NAME <u>Melvina Bush</u>		14. NAME OF HUSBAND OR WIFE <u>Reuben 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>None</u>		17. INFORMANT <u>Rosie Lee Jones 3323 Wabash</u> Address		
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 Vascular Accident</u>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
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 <u>Kansas City</u>		STATE <u>Missouri</u>
21. I attended the deceased from <u>2-6-62</u> to <u>2-10-62</u> and last saw her <u>alive</u> on <u>2-10-62</u> Death occurred at <u>3:17</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Frank Ellis</u> (Degree of title)			22b. ADDRESS <u>2400 Cherry</u>		22c. DATE SIGNED <u>2-13-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Lawn</u>		23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u>		(State)
24. FUNERAL DIRECTOR <u>Watkins Bros. Funeral Home 18th &amp; Benton</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-13-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 Frank Ellis

DEPT. OF HEALTH  
SAN FRANCISCO

**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 Dr. R. Watkins

Licensed Embalmer No. 4500

P. O. Address 18th & Benton

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.