

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003
8214-62-032982
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. _____ Registrar's No. _____

FILED AUG 31 1962

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59			
1			
2 <u>225</u>			
3			
4 <u>0</u>			
5 <u>1</u>			
6			
7 <u>0</u>			
8 <u>2</u>			
9			
10			
11			
12 <u>80-0</u>			
13			
<u>80</u>	SHOULD READ	BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in lb. <u>15 yrs. 4 mo. 21 days.</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>St. Louis State Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1002a Chestnut St.</u>	
3. NAME OF DECEASED (Type or print) First <u>EMORY</u> Middle Last <u>TURNER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Sep <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-93</u>
9. AGE (last birthday) <u>68 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>formerly: Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Frederickstown, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>J.A. Turner</u>		13b. MOTHER'S MAIDEN NAME <u>Anna (Turner)</u>	
14. NAME OF HUSBAND OR WIFE <u>Unknown</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.		17. INFORMANT Address <u>Records of St. Louis State Hospital</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>Bronchogenic - carcinoma with metastasis</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) <u>Arteriosclerotic heart disease</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 _____ 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>3-10-47</u> to <u>7-31-62</u> and last saw him alive on <u>7-31-62</u> Death occurred at <u>3:05 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. <u>Edward G. Dewein, M.D.</u>			
22a. SIGNATURE (Degree or title) <u>Edward G. Dewein M.D.</u>		22b. ADDRESS <u>5400 Arsenal St.</u>	
22c. DATE SIGNED <u>8-1-62</u>		23. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8-31-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	
24. <u>Rowland P. Ker Mortuary Service</u> <u>4104 Manchester Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 23 1962</u>	
26. REGISTAR'S SIGNATURE <u>Loan Smith, M.D.</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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.