Health, Welfare Public Service

. 300
1-56

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36325 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9575

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO — Inside Limits Yes ✓ No ☐	c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ✓ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY Hosp. — Length of stay in 1b 9/16	d. STREET ADDRESS (If outside, give location) 3846 HUMPHREY — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EMMA	E.	TURLEY	OCT	17	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ✓ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE		APR. 29 1881	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	At Home	Mo.	U-S-A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN ARMBRUSTER	UNKNOWN

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 Address
	None	CLARENCE TURLEY 4985 FAIRVIEW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — 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) 331.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐	SUICIDE ☐	HOMICIDE ☐	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 ☐ NOT WHILE AT WORK ☐	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 ____ to ____ and last saw her/him alive on ____
Death occurred at 900 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or Title)	22b. ADDRESS	22c. DATE SIGNED
James M Kelly Deputy Coroner	1300 Clark	10-20-56

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
BURIAL	OCT 20 1956	PARK LAWN CEM	ST LOUIS	MO

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Thomas Kutis	2906 Gravois	OCT 20 1956	Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student ..... Signed .....

Signature of Student Embalmer

Licensed Embalmer No. 434

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.