URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JAN 13 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12603 — 60-048017 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis-Little Rock Hospital, Inc.
Inside Limits Yes X No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes X No
d. STREET ADDRESS (If outside, give location): 3846 Humphrey
Reside on Farm Yes No

3. NAME OF DECEASED (Type or print): First William Middle Lee Last Turley

4. DATE OF DEATH: Month DEC Day 30 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married Never Married Widowed X Divorced
8. DATE OF BIRTH: 10-3-1868
9. AGE (last birthday): 92 — 92
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): Pensr. Mail Handler
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and state or country): MISSOURI
12. CITIZEN OF WHAT COUNTRY: U-S-A

13a. FATHER'S NAME: JOSEPH TURLEY
13b. MOTHER'S MAIDEN NAME: ELIZABETH TERRY
14. NAME OF HUSBAND OR WIFE: EMMA TURLEY (DEC'D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: —
17. INFORMANT Address: DELLA TURLEY 3846 HUMPHREY ST.

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): Fracture Femur - Right — INTERVAL BETWEEN ONSET AND DEATH: 12-20-60
DUE TO (b): Chronic Myocarditis
DUE TO (c): Cardiac Asthma
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

O.K. Jaylen Jones M.D. 1-3-61

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 904.0 — 21

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO X
20a. ACCIDENT X SUICIDE HOMICIDE
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.): Fall at home - 12-20-1960
20c. TIME OF INJURY Hour 5:00 p.m. Month, Day, Year 12-20-60: St. Louis. Mo.
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 16 HOME
20f. CITY, TOWN, OR LOCATION COUNTY STATE: St. Louis. Mo.

21. I attended the deceased from December 20, 1960 to December 30, 1960 and last saw her/him alive on DEC-30-1960
Death occurred at 8:35 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Joseph A. Leuibeck M.D.
22b. ADDRESS: 1755 S. Grand Blvd.
22c. DATE SIGNED: 12-30-60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: JAN 2. 1961
23c. NAME OF CEMETERY OR CREMATORY: PARK LAWN CEMETERY
23d. LOCATION (City, town, or county) (State): ST. LOUIS CO., MO.

24. FUNERAL DIRECTOR ADDRESS: Kutis Funeral Home, St. Louis Mo.
25. DATE RECD. BY LOCAL REG.: DEC 30 1960
26. REGISTRAR'S SIGNATURE: Earl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Eleanor Lovine

Signature of Student Embalmer

Licensed Embalmer No. 340 3

P. O. Address 2906 grov

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