

REC'D OCT 21 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

32412  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 480  
 (b) Township Provine Primary Registration District No. 55-53 B Registered No. 205-  
 (c) City Little Blue Mo (d) Street No. Jackson Co Home St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Walter Turner 656

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 2:30 PM

3. SEX male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-19-38 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from June 1-38, 1938, to Sept. 19-, 1938

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw him alive on Sept 19, 1938. Death is said to have occurred on the date stated above, at 2:30 m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
about 78

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

Date of onset

Acute + mixed Insufficiency

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Beau Co Mo

Other contributory causes of importance:

FATHER 13. NAME Anthony Turner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Ray Exam Was there an autopsy? no

MOTHER 15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1938

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT Ray M. Turner  
 (ADDRESS) 2008 Wabash

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE B.R. Turner Cemetery DATE 9-23- 1938

24. Was disease or injury in any way related to occupation of deceased?

If so, specify L.W. Booker

(Signed) \_\_\_\_\_, M. D.

19. FUNERAL DIRECTOR (NAME) Fisher & Greenstreet  
 (ADDRESS) 1819 E 15th St. K.C. Mo.

20. FILED 9-23- 1938  
 Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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, Edw J

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed Edw J Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E 15th St N 16 700

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

32412  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 400  
 (b) Township Prairie Primary Registration District No. 5533  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 205-

2. PRINT FULL NAME

Walter Turner  
 (a) Residence, No. \_\_\_\_\_ St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
apt 78

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Nov 10 19\_\_ 38 William J. Fields Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-19 1938

22. I HEREBY CERTIFY, That I attended deceased from

19\_\_ to \_\_\_\_\_, 19\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_ Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) L. W. Booker, M. D.

(Address) 20 28 Vine St.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-32412