

DEC 11 NOV 14 1938

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

35070
Do not use this space.

1. PLACE OF DEATH *Boone* ² Registration District No. *73*
 (a) County *Boone* 1 Primary Registration District No. *3006*
 (b) Township *Columbia* (d) Street No. *5 Ripley St* Registered No. *229*
 (c) City *Columbia* (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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.
656

2. PRINT FULL NAME *NANCY ELIZABETH TURNER*
 (a) Residence, No. *5 Ripley St.* 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

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Matthew A. Turner*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan. 17, 1852*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 8 16
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *at home*
 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) *Winchester Ohio*
 FATHER 13. NAME *John Carlisle*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pennsylvania*
 MOTHER 15. MAIDEN NAME *Margaret Griffith*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Not known*
 17. INFORMANT (ADDRESS) *Mrs. Berkeley Estes Columbia Mo*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Olivet* DATE *10-5-1938*
 19. FUNERAL DIRECTOR (ADDRESS) *Parkers Columbia, Mo.*
 20. FILED *10/14/38* 1938 *Allie Selby* Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-3-1938*
 22. I HEREBY CERTIFY, That I attended deceased from *9-20-1938* to *10-3-1938*, 1938
 I last saw him alive on *10-3-1938*. Death is said to have occurred on the date stated above, at *3:45 p.m.*
 The principal cause of death and related causes of importance were as follows:
Encephalitis
 Date of onset *9-20-38*
 Other contributory causes of importance:
 Name of operation *None* Date of
 What test confirmed diagnosis? *None* Was there an autopsy? *No*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *No* Date of injury
 Where did injury occur? *No* (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury *None*
 Nature of injury
 24. Was disease or injury in any way related to occupation of deceased? *No*
 If so, specify (Signed) *W. D. Bryant*, M. D.
 (Address) *Columbia Mo.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

78

STATEMENT BY LICENSED EMBALMER

I, M. V. Whitehead, Licensed Embalmer No. 3893

hereby certify that the body recorded on the reverse side of this certificate was embalmed by M. V. Whitehead

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed M. V. Whitehead

Licensed Embalmer No. 3893

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

COBERTA ... C. A. ...

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

35-070
 Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No. 73
 (b) Township _____ Primary Registration District No. 3006 Registered No. 229
 (c) City Columbia (d) Street No. _____
 (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

Nancy Elizabeth Turner
 (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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-3 1958

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 8 16

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, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

Encephalitis was of classic epidemic type

Date of onset

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

Other contributory causes of importance: 17

FATHER 13. NAME

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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

MOTHER 15. MAIDEN NAME

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.

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

17. INFORMANT (ADDRESS)

Manner of injury _____
 Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) W. P. Dygart, M. D.
 (Address) Columbia Mo

20. FILED _____, 19____ Local Registrar.

S - 35070