LEC'D JUN 19 1939

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

17979
Do not use this space.

1. PLACE OF DEATH
(a) County Benton 2 Registration District No. 61
(b) Township Alexander 1 Primary Registration District No. 5098 Registered No. 19
(c) City ~~Warsaw~~ Mo (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.

2. PRINT FULL NAME 615 John C Turpen
(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: m
4. COLOR OR RACE: Whb
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Kate Turpen
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 1879
7. AGE: YEARS 59 MONTHS 11 DAYS 2 If LESS than 1 day, ... hrs. or ..... min.

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): Mo

FATHER
13. NAME: Jas Turpen
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

MOTHER
15. MAIDEN NAME: Cassie Easton
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ill

17. INFORMANT (ADDRESS): Eugene Turpin Warsaw Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Crabtree DATE 5/3 1939
19. FUNERAL DIRECTOR (ADDRESS): J R Lucky Wheatland Mo
20. FILED 5/3 1939 Jas A Logan Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 2 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 1932 to April 29, 1939
I last saw h..... alive on April 29, 1939. Death is said to have occurred on the date stated above, at 3:30 a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis following high B.P. for 5 years. Two days had left arm paralysis.	

Other contributory causes of importance: ulcerated diet.

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? No
If so, specify .....
(Signed) Everett Shaw D.O., ~~M. D.~~
(Address) Warsaw Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should stat CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

8

I X12004

1321

RECEIVED
District Health Officer No. 7
District File Number 7-39-91
Date Filed 6-6-39

STATEMENT BY LICENSED EMBALMER

I, J R Luckey, Licensed Embalmer No. 2982

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed J R Luckey

Licensed Embalmer No. 2982

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.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

17979
Do not use this space.

1. PLACE OF DEATH
(a) County Benton Registration District No. 61
(b) Township Alexander Primary Registration District No. 5098 Registered No. 19
(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.

2. PRINT FULL NAME John C. Turpen
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
m	w	m

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.
39	11	2	

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 ..... 19 .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5 - 2 , 1939

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

Myocarditis following High Blood pressure for 5 yrs
He also had left arm paralysis

Other contributory causes of importance:
Left arm Paralysis Agitons
File date May 3 1939.

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) Everett Shaw, ~~M.D.~~ DO
(Address) Warsaw, Mo.

SUPPLEMENTARY

TOWN NA MOORE

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

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

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

X12241

JUN 14 1939

1. PLACE OF DEATH

(a) County.....

(b) Township.....

(c) City..... (d) Str...

(e) Length of residence in city or town where death occurred Y...

2. PRINT FULL NAME.....

(a) Residence, No.....

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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.

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..... 19.....

Local Registrar.

21. DATE OF DEATH (Mo.

22. I HEREBY CE

.....19...

I last saw b..... alive on.....

to have occurred on the date stated above, at...

The principal cause of death and related causes o

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).....M. D.

(Address).....

WRITE PLAINLY WITH INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be readily coded. Exact statement of NOTIFICATION is very important.