

V. S. No. 2
M-11-10-39
Rev. 1-1-42
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8

MAY 15 1940

Registration District No. 820

Primary Registration District No. 6269

Registrar's No. _____

100
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Pantow Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether 2)

In this community 4 weeks
years, months or days

3. (a) PRINT FULL NAME Elijah Turner 656

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race Col

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 8, 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>7</u>	<u>X</u>	<u>28</u>	hr. _____ min. _____

9. Birthplace Pantow Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER { 12. Name Oliver Land Samuel

13. Birthplace _____
(City, town, or county) (State or foreign country)

FATHER { 14. Maiden name Viola Turner

15. Birthplace Shelton Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Wesley Turner

(b) Address Pantow Mo

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation M^o Muller Mo

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7/10/40 (b) W. C. Beckman
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott

(c) City or town Pantow Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
year 1940 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death No doctor attended either mother or death. Baby had suffered with acute influenza since birth. Died while coughing in course of these spells.

Duration _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy none

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

732 (Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature W. C. Beckman
Address Charleston Mo Date signed 5-8-40

RECEIVED

District Health Officer No. 2,

District File Number 540-1042

Date Filed 5/14/40

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, or by _____

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

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.)

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