

JUN 17 1940
Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kans. City Mo.
(c) Name of hospital or institution: 1845 Jarboe
(If not in hospital or institution, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution none
In this community 40 yrs. (Specify whether years, months or days)

8. (a) PRINT FULL NAME WM. TURNER (Wm. Turner)

8. (b) If veteran, name war No. 8. (c) Social Security No. No.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Josie Turnery 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 65 Months — Days — If less than one day — hr. — min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER
12. Name Thomas Turner
13. Birthplace Tenn.
14. Maiden name Not known
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Josie Turner

(b) Address 1845 Jarboe

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-6-40
(Month) (Day) (Year)

(c) Place: burial or cremation Bluff Ridge Rural

18. (a) Signature of funeral director W. A. L.

(b) Address 1409 & 12th St

19. (a) May 6, 1940 (Date received local registrar) (b) M. M. Cronow (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Jackson (b) County Kaw
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1845 Jarboe
(If rural, give location)
(e) If foreign born, how long in U. S. A. — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-1-40 day 1 hour 7 minute 18 M.

21. I hereby certify that I attended the deceased from 10:45 AM 1940; that I last saw him alive 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardium
Due to rupture of Arch aorta
Due to aneurysm of aorta
Other conditions (Include pregnancy within 3 months of death) 96

Major findings: Of operations —
Of autopsy —

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? —

While at work? (Specify type of place) (e) Means of injury —
23. Signature Dusell (M. D. or other) —
Address — Date signed —

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

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.

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.....

W. Harris, Sr.
.....

Licensed Embalmer No. *3388*

P. O. Address. *K.C. MO.*

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.