

Registration District No. 175

Primary Registration District No. 5246

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town New Cambria, (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 _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME JIMMIE TURNER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased May 27 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 3 hr. 0 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Charley Turner

13. Birthplace New Cambria, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Alpha Phipps

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

16. (a) Informant Charles Turner

(b) Address New Cambria, Mo.

17. (a) Burial (b) Date thereof May 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine Cemetery

18. (a) Signature of funeral director Charles Turner

(b) Address New Cambria, Mo.

19. (a) 5/22/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

12. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Chariton

(c) City or town New Cambria, Mo. (Rural)
(If outside city or town limits, write "RURAL")
Bee Branch Township

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22
year 1940 hour 12 minute _____ M.

21. I hereby certify that I attended the deceased from 5/22/40
5/22, 1940, to 5/22, 1940,

that I last saw him alive on 5/22, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Premature Birth.

Due to _____

Due to 159

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

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?
1103

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature [Signature] (M. D. or other) MD

Address Bucklin, Mo. Date signed 5/22/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 8,
District File Number 7-15-40
Date Filed

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.