

No. 2
4-18-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

22 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22942

Registration District No. 807

Primary Registration District No. 6052

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Shrewsbury

(b) City or town Coatsville
(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 9
(Specify whether)

In this community
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Schuyler

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

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

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

3. (a) PRINT FULL NAME Israel Turnpough

3. (b) If veteran, name war none

3. (c) Social Security No. 026

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 12 year 1940 hour 2 minute 14 M.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased aug 12 1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 26 1940 to June 12 1940 that I last saw him alive on June 10 1940 and that death occurred on the date and hour stated above.

Immediate cause of death tuberculosis Duration about 2 yrs

8. AGE: Years 80 Months 10 Days 0 If less than one day hr. _____ min. _____

Due to _____

Due to _____

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

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

10. Usual occupation Farmer

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name John Turnpough

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

14. Maiden name _____

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____

(b) Address _____

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

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

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof June 14 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation Bethel Cemetery

717 While at work? _____ (Specify type of place)

Means of injury _____

18. (a) Signature of funeral director morehead

(b) Address San Carter mo

23. Signature J.H. Keller (M. D. or other) _____

Address San Carter Date signed _____

19. (a) June 14 1940 (b) _____
(Date received local registrar) (Registrar's signature)

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

8

23

RECEIVED

District Health Officer No. 10

District File Number 2-40-183

Date Filed

JUL 18 1940

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.....

June Morehead

Registered Apprentice No.

working under my personal supervision.

Signed

Morehead

Licensed Embalmer No. 3731

P. O. Address Lancaster, Mo.

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22947**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **807**

Primary Registration District No. **6022**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County **Schuyler**
(b) City or town **Christon T.P.**
(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 _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Israel Turnpanger

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 **wid**

6. (b) Name of husband or wife _____

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

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

8. AGE: Years **80** Months **10** Days **0** If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **6** day **12** year **1930** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the _____ and hour stated above; immediate cause of death **Tuberculosis** Duration **27**

Due to **apex of Right Lung**

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) **27**

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature **J. H. Keller** (M. D. or other) _____

Address **Lancaster Mo** Date signed _____

SUPPLEMENTAL

S-22942