DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23112

Registration District No. 907 — Primary Registration District No. 4578 — Registrar's No. 15

1. PLACE OF DEATH:
(a) County: Wright
(b) City or town: Mansfield (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 years, months or days): 4 yr. 5 mo. 17 Days
In this community: 65

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Wright
(c) City or town: Mansfield (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: Moses Alanzo Turner
3. (b) If veteran, name war:
3. (c) Social Security No.: (492-18-2571)

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Lillie Turner
6. (c) Age of husband or wife if alive: 66 years
7. Birth date of deceased: JAN. (Month) 10 (Day) 1876 (Year)

8. AGE: Years 64 Months 5 Days 17 If less than one day hr. min.

9. Birthplace: Mansfield (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Store Mgr.
11. Industry or business: Dry Goods Store
FATHER
12. Name: John Turner
13. Birthplace: Tenn. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Elizabeth White
15. Birthplace: Tenn. (City, town, or county) (State or foreign country)
16. (a) Informant: Lillie Turner
(b) Address: Mansfield Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June [illegible] (Month) (Day) (Year)
(c) Place: burial or cremation: Mansfield Cem.
18. (a) Signature of funeral director: [illegible]
(b) Address: Mansfield Mo
19. (a) June 29, 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27th year 1940 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from June 25, 1940 to June 27, 1940 that I last saw him alive on June 27, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Hemorrhage — Duration: 2 days
Due to:
Due to:
Other conditions: Strangulation
(Include pregnancy within 3 months of death)

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

23. Signature: J. A. Furson (M. D. or other)
Address: Mansfield Mo Date signed: June 28, 1940

(Licensed Embalmer's Statement on Reverse Side)

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

23

RECEIVED

District Health Officer No. 6

District File Number 740-2303

Date Filed JUL 8 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____

Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town _____
(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 years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEDENT:
(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. 74 yrs.

3. (a) FULL NAME _____
3. (b) If veteran, name war _____
3. (c) Social Security No. _____
4. Sex _____
5. Color or race _____
6. (a) Single, widowed, married, divorced _____
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 _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ 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 _____ Duration _____
Due to _____
Due to _____

10. Usual occupation _____ (City, town, or county) (State or foreign country)
11. Industry or business _____
12. Birthplace _____ (City or town) (State or foreign country)
13. Birthplace _____ (City or town) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City or town) (State or foreign country)
16. (a) Father _____
(b) Mother _____
17. (a) Informant _____
(b) Address _____
18. (a) Undertaker _____ (b) Address _____
(Licensed undertaker or director) (Registrar's signature)

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 F. A. Steffe

Licensed Embalmer No. 32-2

P. O. Address Mansfield Mo

19. Date of death _____ (Month) (Day) (Year)
20. Place of death _____ (Hospital or institution) (City or town) (County) (State)
21. Cause of death _____ (Duration) (Immediate cause) (Due to) (Due to)
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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.

(Licensed Embalmer's Statement on Reverse Side)

WHITE LEGAL—FOR USE OF VITAL STATISTICS

PHYSICIAN

Underline the cause to which death should be charged statistically.

BLACK INK—MAKE A PERMANENT RECORD

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23112

Registration District No. 907 Primary Registration District No. 45-48 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Mansfield
(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 years, months or days)

In this community

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 Moses Alanzo 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 M

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 64 Months 5 Days 17 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1940 hour minute 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 Pulmonary Hemorrhage — Duration

Due to Do not Know the Cause This man was never sick

Due to never had a doctor in his life time and not left a Physical Examination no operation — Time Patient Lived

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

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature L. A. Fusson (M. D. or other)

Address Mansfield