

AUG 23 1940

State File No. _____

Registration District No. 968

Primary Registration District No. 6183

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Crawford Washington
(b) City or town Ishmael
(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

2. USUAL RESIDENCE OF DECEASED: WASHIN CTON

(a) State Missouri (b) County Crawford
(c) City or town Ishmael
(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 Arthur Turner 656

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

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

6. (b) Name of husband or wife Mattie Turner 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Oct. 20 1892
(Month) (Day) (Year)

8. AGE: Years 47 Months 8 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name William Turner

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

14. Maiden name Elizabeth Martin

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

16. (a) Informant Mrs. Mattie Turner

(b) Address Ishmael, Mo

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

(c) Place: burial or cremation Quaker, Mo.

18. (a) Signature of funeral director Ed Hallam

(b) Address Cuba, Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from July 1st
_____, 19____, to July 18, 19____
that I last saw him alive on July 18, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death T. B. of kidneys.

Due to Delaware Hospital about 2 months
Due to their diagnosis as referred to me.

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? 960
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Houston M.D. (M. D. or other) _____
Address Courtois Mo Date signed 8-15-40

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

MOTHER FATHER

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.....

John S. Holloway

Licensed Embalmer No.....

3643

P. O. Address.....

Cuba, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26 538**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **968**

Primary Registration District No. **6183**

Registrar's No.

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

1. PLACE OF DEATH:
 (a) County Washington
 (b) City or town Bellevue, Mo.
 (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 _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME Arthur 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 47 Months 8 Days 0 If less than one day _____ 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 17, 40 (b) D. W. Norton
 (Date received local registrar) (Registrar's signature)

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

DECEASED CERTIFICATION
 20. DATE OF DEATH: Month July day 20
 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 _____

Due to _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other)
 Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

