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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31432**
Registrar's No. **987**

Registration District No. **85** Primary Registration District No. **1001**

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
610 Lincoln Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution one week 2
(Specify whether
In this community Sixty one years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Gertrude Marie Turner

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Goddie Turner 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 25, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 3 14 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Charles Vance

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

14. Maiden name Martha LaCroix

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

16. (a) Informant Mrs. George DeNeen

(b) Address 610 Lincoln Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director L. R. Schepfen 7. Hm
(b) Address 602 South 10th Street

19. (a) Sept 10, 1940 (Date received local registrar) (b) F. J. Nestleburg (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 608 Lincoln Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9th day September
year 1940 hour 1 pm minute 10 PM.

21. I hereby certify that I attended the deceased from Aug. 8,
1940 to Sept. 9th, 1940;
that I last saw her alive on Aug. 8, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Colon
Cachexia
traumatis

Due to Inspection Cancer of Colon
Duration approx. 2 years

Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death) H/L

Major findings:
Of operations none
Of autopsy none
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? Yes (Specify type of place) (e) Means of injury _____

23. Signature Alma J. Young (M. D. or other) _____
Address 216-219 Phys. & Surg. Bldg. Date signed 9.10.40

Dr. J. J. J. J. J.

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, & by _____

Mollie E. Sidenfaden, Registered Apprentice No. 145
working under my personal supervision.

Signed *R. V. Wurst*

Licensed Embalmer No. 3876

P. O. Address *St. Joseph 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.