

NOV 12 1940
Registration District No. 99

Primary Registration District No. 1002

Registrar's No. 1853

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town _____
(c) Name of hospital or institution: St. Joseph Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 hrs.
In this community Non-Resident
years, months or days

3. (a) PRINT FULL NAME TURNER, FRANCES
(b) If veteran, name war No
(c) Social Security No. None

4. Sex F 5. Color or race White
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 10 1923
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>17</u>	<u>7</u>	<u>25</u>	_____ hr. _____ min.

9. Birthplace Kafayette - Co. V S
(City, town, or county) (State or foreign country)
10. Usual occupation School Sit. S

11. Industry or business _____
12. Name Henry W Turner
13. Birthplace Kafayette - Co. S
(City, town, or county) (State or foreign country)
14. Maiden name Madalene Sidenet.
15. Birthplace Kafayette - Co. S
(City, town, or county) (State or foreign country)

16. (a) Informant Henry W Turner
(b) Address Maplewood - Mo.
17. (a) Burial? (b) Date thereof 10-6-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant - Paitre
18. (a) Signature of funeral director Blair Hand
(b) Address Adrian Mo.
19. (a) 10-4-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 3 1/2 mi. N. Bates City, Mo
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10-5-40
year _____ hour _____ minute 5 A. M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I performed the autopsy _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Laceration & Hemorrhage of Brain
Duration _____

Due to Automobile Fracture
Due to Poisoning
Other conditions 210 gm
(Include pregnancy within 9 months of death)

Major findings: _____
Of operations 16
Of autopsy am
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) Accident
(b) Date of occurrence 10-4-40
(c) Where did injury occur? Home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - Non-collision
(Specify type of place) (e) Means of injury _____
While at work _____
23. Signature Russell Lusser (M. D. or other)
Address Adrian Date signed _____

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, fact should be so stated above.

No. 2
-1-4-41
5-17-39
I X28396

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34337
Registrar's No. 3853

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C.
(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:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5
year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

3. (a) PRINT-FULL NAME Frances Turner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

Immediate cause of death Automobile Traumatism *Durgion*
Demerol
Due to Automobile Traumatism
Due to Demerol

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

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 17 Months 7 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

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) 10/4/1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

Other conditions _____ (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? _____

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

23. Signature Russell W. Kern (M. D. or other) _____

Address K.C. Date signed _____

SUPPLEMENTAL

(Licensed Embalmer's Statement on Reverse Side)

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

HOWLING MOON

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, fact should be so stated above.