

NOV 12 1940
Registration District No. _____

Primary Registration District No. _____

Registrar's No. **4061**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether
In this community -----
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City, Kansas
(If outside city or town limits, write "RURAL")
(d) Street No. 1289 Seminary
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Daniel Turner

(b) If veteran, name war None (c) Social Security No. 510-16-3888

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

(b) Name of husband or wife Elizabeth Hunter Turner (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Oct. 14th, 1875
(Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days 6 If less than one day
hr. _____ min. _____

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

10. Usual occupation Baker

11. Industry or business West End Bakery

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Elizabeth Turner,

(b) Address 1289 Seminary, K.C.Ks.

17. (a) Burial (b) Date thereof Oct. 22-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.

(b) Address 2825 Indep. Blvd. K.C.Mo.

19. (a) 10-22-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20th
year 1940 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from 10-10-40
1940, to 10-19, 1940
that I last saw him alive on 10-19, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Angina pectoris Duration 3 weeks

Due to myocarditis ?

Due to _____

Other conditions (Include pregnancy within 3 months of death) PH. W.

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 P.M. Nunn (M. D. or other) _____

Address 524 1/2 Blvd Date signed 10-21-40

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

MOTHER FATHER

MC

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

H. D. Blackman

Licensed Embalmer No.

3639

P. O. Address

K. L. New

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.