

APR 15 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

10815  
Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 478  
(b) Township \_\_\_\_\_ Primary Registration District No. 42221 Registered No. 18  
(c) City Fayette (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Martha Ann Turner,

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF William F. Turner. (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-9th 1846

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
94 3 27

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri,

13. NAME Thomas S. Smith.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri,

15. MAIDEN NAME Jane Patterson,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pensylvania,

17. INFORMANT (ADDRESS) Mrs John Palmer.  
Fayette, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Walnut Ridge, DATE 3-9th 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Guy T. Halley.  
Fayette, Mo.

20. FILED 3-9- 1941 Anna R. [Signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6th 1941

22. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1941 to 3-6, 1941.  
I last saw her alive on 3-6, 1941. Death is said to have occurred on the date stated above, at 5:10 a.m.  
The principal cause of death and related causes of importance were as follows:

Arterio Sclerosis Date of onset 3-2-41

Other contributory causes of importance: Ch. Arterio Sclerosis

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis? None Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) W. B. Bloom M. D.  
(Address) Fayette, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor.

97

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 7-10-41

**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 Guy T. Kessing  
Licensed Embalmer No. 2966  
P. O. Address Jayette M

**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.**

No. 2  
-14-41  
-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10815-

Registration District No. 378

Primary Registration District No. 4222

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Fayette  
(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 Missouri (b) County Howard  
(c) City or town Fayette, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. West Main  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (c) PRINT FULL NAME

Martha Ann Turner

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

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

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  
94 3 27 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 \_\_\_\_\_ (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 \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 6-7-41 (Date received local registrar) Anna P. Paul (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 6 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw him alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 W. A. Bloom (M. D. or other) \_\_\_\_\_ Address Fayette Mo. Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

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

SUPPLEMENTARY

1941  
5-10815

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**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10815-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 374

Primary Registration District No. 4222

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Fayette  
(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

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

Martha Ann Turner

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

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

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 min.  
94 3 27

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

10. Usual occupation

11. Industry or business

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 Mar day 6 year \_\_\_\_\_ 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. Immediate cause of death Uremic Coma Duration \_\_\_\_\_

Due to Chronic hepatitis

Due to 12/18

Other conditions Chr arterio sclerosis (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 W. B. Bloom (M. D. or other) M.D.

Address Fayette Date signed 2-17-41

SUPPLEMENTARY