

Registration District No. 532

Primary Registration District No. 5711

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon

(b) City or town La Plata Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether)

In this community all his life
years, months or days

3. (a) PRINT FULL NAME James Foster Turner

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 1

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

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

7. Birth date of deceased Oct 15 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>5</u>	<u>16</u>	hr. min.

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

10. Usual occupation Laborer

11. Industry or business ✓

12. Name James H. Turner

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

14. Maiden name Susan Henderson

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

16. (a) Informant Mrs R. L. Lucas

(b) Address Route #1 Gary Ind

17. (a) Burial (b) Date thereof April 3 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Plata Mo

18. (a) Signature of funeral director D. S. Christie

(b) Address La Plata Mo

19. (a) Apr 3 1941 (b) Laurie Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. 1 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 1 year 1941 hour 7:45 minute 1 M.

21. I hereby certify that I attended the deceased from Mar 29 1941 to Apr 1 1941; that I last saw him alive on Apr 1 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of sigmoid Colon

Due to 468

Other conditions (Include pregnancy within 3 months of death) Uremia

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? _____

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

23. Signature H. O. Newton (M. D. or other) 0
Address La Plata Mo Date signed _____

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 5-41-946

Date Filed MAY 14 1941

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.