DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28941

FILED SEP 12 1941

Registration District No. 609

Primary Registration District No. 1363

Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Newton
(b) City or town: Neosho
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sale-B owman Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Arkansas (b) County: Sebastian
(c) City or town: Fort Smith
(If outside city or town limits, write "RURAL")
(d) Street No.: 2516 Brockman
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME: SHIRLEY FAYE TURNER
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Infant
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: April 4, 1941 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
	3	4	hr. min.

9. Birthplace: Fort Smith, Arkansas (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name: Willard Turner
13. Birthplace: Sallisaw, Oklahoma (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Molly Dunning
15. Birthplace: Greenwood, Arkansas (City, town, or county) (State or foreign country)
16. (a) Informant's own signature
(b) Address: Fort Smith, Arkansas
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation: Fort Smith
18. (a) Signature of funeral director: Lee A Carroll
(b) Address: Greenville Mo
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8th year 1941 hour 11:50 minute p. M.
21. I hereby certify that I attended the deceased from 7-8-41, 19__, to 7-8-41, 19__; that I last saw h er alive on 7-8-41, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Fractured Skull and Crushed Chest - and Shock	
Due to: Car Accident	
2 Car Collision	
Due to:	
Other conditions: none (Include pregnancy within 3 months of death)	
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): Car Accident
(b) Date of occurrence: July 8-41 - 8 C
(c) Where did injury occur? Near Gravelle McDonald Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway - #88 (Specify type of place)
While at work? No (e) Means of injury: Car accident
23. Signature: Melvin C Bowman (M. D. or other) M.D.
Address: Neosho, Missouri Date signed 7-11-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 941-1445
Date Filed SEP 8 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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28941

Registration District No. 609 Primary Registration District No. 4363 Registrar's No.

1. PLACE OF DEATH:

(a) County: Newton

(b) City or town: Neosho
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME: Shirley F. 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: Infant

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: April (Month) 4 (Day) 1941 (Year)

8. AGE: Years | Months: 3 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) 7-11-41 (Date received local registrar) (b) Arnal A. Salem M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day year 1941 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 — 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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY