

FILLED NOV 14 1941

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

355777
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 55
(b) Township Anderson Primary Registration District No. 4033 Registered No. 98
(c) City Anderson (d) Street No. _____ St. _____
(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. ds.

2. PRINT FULL NAME HAZEL E. TURNER

(a) Residence, No. Anderson St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William L Turner
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 23, 1903
7. AGE YEARS 39 MONTHS 3 DAYS 2 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Charleston Missouri

FATHER 13. NAME John Turner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Charleston Mo

MOTHER 15. MAIDEN NAME Mattie Wright

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Charleston Mo

17. INFORMANT (ADDRESS) William L Turner Anderson, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Figgatt ark DATE 10-26 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gloyd Kinsell Figgatt, ark

20. FILED Nov 26 1941 Wanda Mason Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-25 1941

22. I HEREBY CERTIFY, That I attended deceased from 10/19 1941, to 10/19 1941
I last saw her alive on 10/19 1941. Death is said to have occurred on the date stated above, at 5 P m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of uterus Date of onset _____
Other contributory causes of importance: 488

Name of operation None Date of _____
What test confirmed diagnosis? _____ 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? _____
If so, specify _____
(Signed) R. M. Quire, M. D.
(Address) Figgatt Ark

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 important.

RECEIVED

District Health Office No. 2,

District File Number 1141-1539

Date Filed 11/12/14

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, above space should be left blank.