

OCT 28 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36297

Registration District No. 560

Primary Registration District No. 6094

Registrar's No. 4

1. PLACE OF DEATH:

(a) County **Shelby**
(b) City or town **Rural Jefferson Twsp**
(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 **40 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Shelby** 102
(c) City or town **Clarence Mo Rural** 0
(If outside city or town limits, write "RURAL")
(d) Street No. **Jefferson Township** 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Stephen Brink Turner**

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

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Addie Turner**
6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **August 13th 1871**
(Month) (Day) (Year)

8. AGE: Years **70** Months **8** Days **6**
If less than one day hr. min.

9. Birthplace **Knox Co Ill**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____

MOTHER FATHER { 12. Name **William E Turner**

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

14. Maiden name **Not Known**

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

16. (a) Informant **Mrs Addie Turner**

(b) Address **Clarence Mo**

17. (a) **Burial** (b) Date thereof **9/21/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clarence Mo**

18. (a) Signature of funeral director **Mellon & Parklan**

(b) Address **Shelby Mo**

19. (a) **9-20-41** (b) **ROY HAMILTON**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **19**
year **1941** hour **6** minute **9** M.

21. I hereby certify that I attended the deceased from **March 23 1938** to **Sept 19 1941**
and that death occurred on the date and hour stated above.
that I last saw him alive on **Sept 18 1941**

Immediate cause of death: **Chronic Myocarditis** 3 yrs

Due to **mitral stenosis** 40-50 yrs

Due to **Rheumatic fever in childhood** 3 months about 1890

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: **93d**
Of operations _____
Of autopsy _____

Duration
3 yrs
40-50 yrs
3 months about 1890

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)
(c) Means of injury _____
23. Signature **D. L. Sulan** (M. D. or other) **OMD**
Address **Clarence Mo** Date signed **Sept 20 1941**

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

RECEIVED

District Health Officer No. 10

District File Number 10-41-1932

Date Filed OCT 24 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.....

Henry J. Barkley

Licensed Embalmer No. 3835

P. O. Address Shelburne Vt

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.