

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21782

FILED JUN 29 1942

Registration District No. \_\_\_\_\_ Primary Registration District No. 11334 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town East Prairie, Mo  
(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 9 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Mississippi  
(c) City or town East Prairie, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN TURNER JR.  
3. (b) If veteran, name war ✓ 3. (c) Social Security No. none  
4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced U  
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)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 22 year 1942 hour 11.10 minute 9 M.  
21. I hereby certify that I attended the deceased from April 1942 to June 27 1942 that I last saw him alive on June 15 1942 and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_ Duration 17

8. AGE: Years 9 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Mississippi (City, town, or county) Mo (State or foreign country)

Due to Tuberculosis Bone  
Tuberculosis lungs  
Due to \_\_\_\_\_ 6mo  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name John Shelby Turner  
13. Birthplace Mississippi (City, town, or county) Mo (State or foreign country)  
14. Maiden name Martha Ella Hedrick  
15. Birthplace Mo (City, town, or county) \_\_\_\_\_ (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant John Shelby Turner  
(b) Address East Prairie, Mo  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-42 (Month) (Day) (Year)  
(c) Place: burial or cremation Travis Shelby  
18. (a) Signature of funeral director Logwood & Co  
(b) Address East Prairie, Mo  
19. (a) 6-23-1942 (Date received local registrar) (b) Fannie E. Bugman (Registrar's signature)

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) Manner of injury \_\_\_\_\_  
23. Signature S. P. Martin (M. D. or other) \_\_\_\_\_  
Address East Prairie, Mo Date signed 6-23-42

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

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JUN 29 1942

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.....

.....  
working under my personal supervision.

*James E. Scott*

..... Registered Apprentice No. ....

Signed.....

*Travis Shelby*

..... Licensed Embalmer No. *2776*

..... P. O. Address, *East Prussia, Pa.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to copy the above constitutes grounds for revocation of license.)

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

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21782  
Registrar's No. 35

Registration District No. 567

Primary Registration District No. 4334

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town East Prairie  
(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 9 yrs  
years, months or days

3. (a) PRINT FULL NAME John Turner Jr

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 2 1932  
(Month) (Day) (Year)

8. AGE: Years 9 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Fannie E. Bryman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mississippi  
(c) City or town East Prairie  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12  
year 1942 hour \_\_\_\_\_ minute 10 a.m.

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

Immediate cause of death: tuberculosis of bone  
9 tuberculosis of lung

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
/Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

