No. 2
-9-4-41
-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Turner

State File No. 41235

LED JAN 15 1943

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 118

61
3
2

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

1. PLACE OF DEATH:

(a) County Macon

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

(c) Name of hospital or institution: 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61 0

(c) City or town 0
(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 0

3. (a) PRINT FULL NAME Fred Gross

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Feby 1 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	10	24	..... hr. ..... min.

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

10. Usual occupation Laborer

11. Industry or business .....

FATHER
12. Name Dont Know
13. Birthplace Dont Know 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace Dont Know 9 (City, town, or county) (State or foreign country)

16. (a) Informant Ray Billiter
(b) Address Macon Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12/26/42 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director Albert Skinner
(b) Address Macon Mo

19. (a) 1/5/43 (Date received local registrar) (b) Jora B. Hunckler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 25
year 1942 hour 4 P minute ..... M.

21. I hereby certify that I attended the deceased from Nov 1942 to Dec 25 1942
that I last saw him alive on Dec 25 1942
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Insufficiency	3 mo ±
Due to Mitral Stenosis	20 yr ±
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

92

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 0

23. Signature F F Turner (M. D. or other)
Address Macon Date signed 1/5/43

1037 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 1-43-134
Date Filed Jan-13-1943

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 wi the above constitutes grounds for revocation of license.)

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

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. 41235

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 118

1. PLACE OF DEATH:

(a) County: Macon

(b) City or town: Macon (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: County Infirmary (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) 1 1/2 years

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Macon

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

(d) Street No.: Rural (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Fred Shaw

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: M

5. Color or race: B

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: Feb (Month) (Day) (Year)

8. AGE: Years 52 Months 10 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

MOTHER FATHER

12. Name

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

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) 2/1/43 (Date received by local registrar) (b) Nora B. Shuncklen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 26 year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him 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)

(b) 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

SUPPLEMENTARY