

20817

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

JUN 25 1943 33
Registration District No. _____

Primary Registration District No. 5116

Registrar's No. 5

1. PLACE OF DEATH:

(a) County BOONE
(b) City or town RURAL-BOURBON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BOONE
(c) City or town RURAL-
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4th
year 1943 hour 11 minute 30 P. M.
21. I hereby certify that I attended the deceased from May 15
_____, 1943, to June 4, 1943
that I last saw her alive on June 4, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial insufficiency 6-mos
Duration _____

Due to ✓
Due to ✓

Other conditions lung congestion 20g
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓
PHYSICIAN ggb
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 injury)
(e) Means of injury _____

23. Signature A. R. M. Lewis (M. D. or other) _____
Address Sturgeon, Mo Date signed 6-6-43

3. (a) PRINT FULL NAME DAISY VIRGINIA 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 WIDOWED

6. (b) Name of husband or wife JESSE TURNER 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased NOV. 30-1876
(Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation HWY.

11. Industry or business _____

MOTHER FATHER { 12. Name JOSEPH SALMOY

13. Birthplace Ky. 1
(City, town, or county) (State or foreign country)

14. Maiden name POLEY SMITH

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

16. (a) Informant's own signature Mrs Austin C Phillips
(b) Address Sturgeon, Mo.

17. (a) Burial (b) Date thereof June 6-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation locust grove

18. (a) Signature of funeral director Barnes & Booth
(b) Address Sturgeon, Mo

19. (a) June 5-1943 (b) Mary Montgomery
(Date received local registrar) (Registrar's signature)

175 (Licensed Embalmer's Statement on Reverse Side)

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

JUN 25 1948

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..... *A. E. Boothe*.....

Licensed Embalmer No. *4087*.....

P. O. Address. *Sturgeon, Me.*.....

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.