

7. S. No. 2  
FORM-5-42  
Rev. 5-17-39  
X3228

26419

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 74

Primary Registration District No. 6273

Registrar's No. ....

1. PLACE OF DEATH:

(a) County North

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

(c) Name of hospital or institution:  
Grant City Mo.  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County North

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

(d) Street No. Grant City Mo.  
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country

3. (a) PRINT FULL NAME CLARA GRAY TURNER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

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

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

7. Birth date of deceased May 22 1956  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

87 1 2 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Clara Gray

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

14. Maiden name unknown

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

16. (a) Informant Mary Myers

(b) Address Grant City Mo.

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof 6-27-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Grant City Cemetery

18. (a) Signature of funeral director Arch J. Duffell

(b) Address Grant City Mo.

19. (a) July 2, 1943 (b) Arlene Scadden  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1943 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from June 20 1943, to June 24 1943 that I last saw her alive on June 24 1943 and that death occurred on the date and hour stated above

Immediate cause of death Stroke  
of the heart

Duration 5 hrs

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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Scadden (M.D. or other)

Address Grant City Mo. Date signed July 2, 1943

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

MOTHER FATHER

**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.....

*Jack C. Dunfee*

Licensed Embalmer No. *3252*

P. O. Address.....

*Front City, Mo.*

**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.**