

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28302

State File No. _____
Registrar's No. 681

Registration District No. 128 Primary Registration District No. 2000

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home, 817 S. Newton
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 817 S. Newton (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOEL PATTY TURNER
(b) If veteran, name war No
(c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month AUG day 19
year 1943 hour 6:00 minute A M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased: April 22 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-14-1935 to 8-19-1943
that I last saw him alive on 8-18-1943
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
60 3 27 hr. min.

Immediate cause of death: Cerebral Hemorrhage

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

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

10. Usual occupation Retired Housewife

Major findings: _____
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Joel H. Haden
13. Birthplace Galloway Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Deshears
15. Birthplace Greene Co. Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
83a!

16. (a) Informant Mrs Harry Elliott
(b) Address Springfield Mo

17. (a) Burial (b) Date thereof 8-21-1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood Cem.

18. (a) Signature of funeral director H. H. Lohmeyer
(b) Address Springfield Mo.

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 _____

19. (a) 8-20-43 (b) Dr W E Handley
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) _____
Address Springfield Mo Date signed 8-20-43

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..... *L. Archie Gorman*
Licensed Embalmer No. *3177*
P. O. Address..... *Amesbury, Mass.*

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.

X