

FILED DEC 18 1943

Registration District No. **5559**

Primary Registration District No. **5559**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Pomona Mo Rt 2**
(c) Name of hospital or institution:
1 On. Good. J. J.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **75 4 B -**
In this community **75 4 B -** years, months, days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Adair**
(c) City or town **Pomona Rt 2**
(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 **Doctor Mearns Turner**

3. (b) If veteran, name war **1** 3. (c) Social Security No.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **2** **W**
6. (b) Name of husband or wife **Ann Turner** alive **0** years
7. Birth date of deceased **9-24-1852**
(Month) (Day) (Year)

8. AGE: Years **91** Months **07** Days **07** If less than one day hr. min.

9. Birthplace **Peters Co., Iowa** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **Alie F. Turner**

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

14. Maiden name **Letta Medgett**

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

16. (a) Informant **Mrs M.C. Briley**

(b) Address **Pomona Mo Rt 2**

17. (a) (b) Date thereof **10/3-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mo. Grav.**

18. (a) Signature of funeral director **W. H. ...**

(b) Address **West Plains Mo**

19. (a) **12-3-43** (b) **Nanette Ferguson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **1**
year **1943** hour **7** minute **25** A.M.
21. I hereby certify that I attended the deceased from **2-7-40** to **10-1-43**
that I last saw h.l. **10-1-** alive on **10-1-** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Prostate** Duration **2 yrs.**

Due to: **51 1/2**
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) **200**
(b) Date of occurrence **none**
(c) Where did injury occur? **none**
(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 **C. Callahan** (M. D. certificate)
Address **Willow Springs, Mo.** Date signed **11-43**

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

16
0
0

RECEIVED

District Health Officer No. 5, 79

District File Number 1273678

Date Filed 12-4-43

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

J. S. Roberton

Licensed Embalmer No. 3437

P. O. Address

West Haven, Conn.

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.