

**RECORDED** MAR 14 1944

Registration District No. 328

Primary Registration District No. 3073

Registrar's No. 6

1. PLACE OF DEATH:  
(a) County Scott  
(b) City or town Chaffee  
(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 years, months or days)

3. (a) PRINT FULL NAME Irene Torrey 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 2 divorced widowed  
6. (b) Name of husband or wife Horatio Francis Turner 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased June 15 1867  
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 28 If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

MOTHER FATHER  
12. Name Hamilton Robbards Torrey  
13. Birthplace Springfield N.Y  
(City, town, or county) (State or foreign country)  
14. Maiden name Eliza Ann Hadlock  
15. Birthplace Kewiston N.Y  
(City, town, or county) (State or foreign country)

16. (a) Informant HA Turner  
(b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 2-16-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Rosehill - Brookfield Mo

18. (a) Signature of funeral director Bisplinghoff & Hubbard  
(b) Address Chaffee Mo

19. (a) 2-13-44 (b) Christa Grace  
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 13 year 1944 hour 1 minute P M.  
21. I hereby certify that I attended the deceased from July 10<sup>th</sup> to July 13<sup>th</sup> 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure  
Due to Acute Dilatation of Heart  
Other conditions (Include pregnancy within 3 months of death) 9/5/4

Major findings: Of operations 9/5/4  
Of autopsy

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) (2) Means of injury 0  
23. Signature W. Turner (M. D. or other)  
Address Chaffee Mo Date signed 7/13/44

Duration  
13 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2

District File Number 344-382

Date Filed 8-3-44

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..... *Mamie Deplinghoff*

Licensed Embalmer No. 3242

P. O. Address..... *Chaffee 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.