

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

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 331

Primary Registration District No. 4499

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Shelby

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

(c) Name of hospital or institution:
O Simpson Hospital Shelbyville
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one day
(Specify whether)

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shelby

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

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 1)

3. (a) PRINT FULL NAME MARY ANN 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 Wm R. Turner

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Aug - 12 - 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>7</u>	<u>14</u>	<u>-</u> hr. <u>-</u> min.

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

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business

12. Name Boliver G. Doyle

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

14. Maiden name Sarah J. Adkinson

15. Birthplace Saline Co. Mo. I
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. S. M. Feely

(b) Address Shelbyville, Mo.

17. (a) Burial (b) Date thereof Mar. 28-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O.C.F. Cemetery

18. (a) Signature of funeral director E. P. Thompson

(b) Address Shelbyville, Mo.

19. (a) Apr. 10, 1944 (b) Marye Good
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 26
year 1944 hour 8:30 minute 15 M.

21. I hereby certify that I attended the deceased from Mar 25
1944 to March 26 1944
What I last saw her alive on March 26 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Duration 24 hr

Due to Hypertension

Due to 94a

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?

(Specify type of place)

While at work? (c) Means of injury

23. Signature S. R. Simpson (M. D. or other) Do

Address Shelbyville Mo. Date signed

RECEIVED

District Health Officer No. 10

District File Number 5-44-999

Date Filed MAY 12 1944

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

Myself, Registered Apprentice No. _____
working under my personal supervision.

Signed

E. P. Thompson

Licensed Embalmer No. 1632

P. O. Address

Shelbyville, 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.

Registration District No. 337

Primary Registration District No. 4889

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Shelbyville Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
(c) City or town Shelbyville-Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Ann 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 W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 12 1892
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days _____ (If less than one day, _____ min.)
9. Birthplace _____ (City, town, or county) (State or foreign country) Mo

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) Madge Good
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar 1944 year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

15957