DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21217

FILED JUN 20 1944

Registration District No. 4

Primary Registration District No. 4059

Registrar's No. 158

1. PLACE OF DEATH:

(a) County: Butler

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

(c) Name of hospital or institution: 0

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 (Specify whether years, months or days)

In this community: 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Butler

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

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

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Ora Dilitha Turnbough

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: married

6. (b) Name of husband or wife: A. Turnbough

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

7. Birth date of deceased: Dec. (Month) 10 (Day), 1892 (Year)

8. AGE: Years 51 Months 4 Days 28 If less than one day hr. min.

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

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Robert T. Aaron

FATHER 13. Birthplace: Ill. (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Nancy Alfred

MOTHER 15. Birthplace: Butler (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature: C. F. Krugh

(b) Address: Etowah Ark.

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

(c) Place: burial or cremation: Burial

18. (a) Signature of funeral director: Lulie D. Russell

(b) Address: Corning Ark.

19. (a) 5-12-44 (Date received local registrar) (b) Belle Hinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8 year 1944 hour 5:45 minute P. M.

21. I hereby certify that I attended the deceased from May 7, 1944, to May 8, 1944, that I last saw her alive on May 8, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Due to: Hr. Fail

Due to:

Other conditions (Include pregnancy within 3 months of death): 336

Major findings: Of operations:

Of autopsy:

Duration

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? (e) Means of injury:

23. Signature: J. J. Farr (M. D. or other)

Address: Neelyville Mo. Date signed: May 11

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(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be currently supplied. Avoid should be stated [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Office No
District File Number 64-7
Date Filed 6-8-

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 Leslie D. Russell

Licensed Embalmer No. 3855

P. O. Address Corning Ark.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

2B
21-41
29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. Tuesday

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County ..... Jan 3 [illegible]

(b) City or town .....
(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 years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(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 Ora Alitha Turnbough

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

4. Sex ..... 5. Color or race ..... 6. (a) Single, widowed, married, divorced .....

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

7. Birth date of deceased ..... (Month) (Day) (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

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) ..... (Burial, cremation, or removal) (b) Date thereof 5-11-44 (Month) (Day) (Year)

(c) Place: burial or cremation Wednesville, Mo.

18. (a) Signature of funeral director Leslie D. Russell

(b) Address Cerning

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... ; that I last saw h... 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)

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

While at work? ..... (Specify type of place) (c) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

2121 7