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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 13 1944
Registration District No. 200

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 64

Primary Registration District No. 2725

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Macon Hudson
(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 _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Macon
(c) City or town Jackson St. Macon Mo.
(d) Street No. _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas F. Turner
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 28 in year 1944 hour 11 minute 17 M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Rene V. Turner (c) Age of husband or wife if alive 41 years
7. Birth date of deceased Oct. 24, 1901
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw h _____ alive on _____
and that death occurred on the date and hour stated above.

8. AGE: Years 42 Months 8 Days 4 If less than one day _____ hr. _____ min.

Immediate cause of death By the accident sinking of the boat in which he was riding, causing him to drown.
Due to _____
Due to (cardiac & injury)

9. Birthplace Shelby County Mo. (City, town, or county) (State or foreign country)
10. Usual occupation physician MD

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations - 183 1/2
Of autopsy - 74

MOTHER FATHER

11. Industry or business _____
12. Name Gas F. Turner
13. Birthplace Shelby Co, Mo. (City, town, or county) (State or foreign country)
14. Maiden name Corry Freeman
15. Birthplace Shelby Co Mo (City, town, or county) (State or foreign country)

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

16. (a) Informant Rene V. Turner
(b) Address 1015 N Jackson Macon Mo
17. (a) Burial (b) Date thereof 7-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Clersue Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 061
(b) Date of occurrence June 28, 1944
(c) Where did injury occur Macon Macon Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on Macon Lake, Macon, Mo
(Specify type of place)
While at work? no (e) Means of injury drown

18. (a) Signature of funeral director Stephen T. Gaddis
(b) Address Macon Mo
19. (a) 7/5/44 (b) Opie B. Dunkler
(Date received local registrar) (Registrar's signature)

23. Signature H. Edward Casner
Address Macon Mo Date signed 6/29/44

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

OCT 5 1948

JUL 9 1950

RECEIVED

District Health Officer No. 70
District File Number 7-44-1280
Date Filed JUL 11 1944

MAY 16 1950

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.....

O. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon 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. 200

Primary Registration District No. (2725)

Registrar's No. 67

1. PLACE OF DEATH:

(a) County Macon Hudson
(b) City or town Macon Hudson
(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)

3. (a) PRINT FULL NAME Thomas J. Turner

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

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

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

7. Birth date of deceased Oct 27
(Month) (Day) (Year)

8. AGE: Years 42 Months 8 Days no Unless than one day _____ min.

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

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

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) (e) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

21999