

FILED NOV 8 1944
Registration District No.

Primary Registration District No. 5289

Registrar's No. 104

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Yoshland - Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home Prothudinuz
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 13 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph S. TURNER

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

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

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

7. Birth date of deceased: MAY 18 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 25 If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business Business

12. Name John Turner

13. Birthplace Unknown Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hulet

15. Birthplace Unknown Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Sarah Turner
(b) Address Yoshland Mo

17. (a) Burial (b) Date thereof 10-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Mo

18. (a) Signature of funeral director Morton General H
(b) Address North Kaw City Mo
19. (a) Oct 13-1944 (b) Guich T. Henry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24
(c) City or town Yoshland Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Yoshland Mo.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country:

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12 2th
year 1944 hour 3:45 minute P M.

21. I hereby certify that I attended the deceased from 10/12/44 to death, 1944 to 1944;
(that I last saw him alive on 10/12/44 and that death occurred on the date and hour stated above.)

Immediate cause of death Cowary occlusion
Duration 8 hrs

Due to AKA
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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?

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

23. Signature W. H. Dunham (M. D. or other) 0
Address North KC Mo Date signed 10/13/44

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

4
0
0

Dunham

RECEIVED

District Health Officer No. 8,

1948

Number

11-6-47

FEB 16 1948

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

John S. Norton

Licensed Embalmer No. 4349

P. O. Address 220 KC 2nd

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.