S. No. 2
M—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40393

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5170

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1923 E 15 St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48
(c) City or town Kansas City Mo 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1923 E 15 th Str 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Daisy D. Turney
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Fe
5. Color or race Wh
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Albert Turney
6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased Dec 29 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	76	11	15	hr. min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business
FATHER
12. Name No Record
13. Birthplace No Record
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name No Record
15. Birthplace No Record
(City, town, or county) (State or foreign country)
16. (a) Informant Nellie Lincoln
(b) Address 1923 East 15 St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-44
(Month) (Day) (Year)
(c) Place: burial or cremation Mt Moreah
18. (a) Signature of funeral director Frank W. Wagner
(b) Address Kansas City Mo
19. (a) 12-19-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 14
year 1944 hour 5:10 minute P M.
21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on CORONER , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Due to Senility
Due to 94a
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations History & Inspection
Of autopsy no

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 James C Walker Coroner (M. D. or other)
Address 1424 Jefferson Bldg Date signed 12-15-44

(Licensed Embalmer's Statement on Reverse Side)

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 Cecil R Matthes

Licensed Embalmer No. 3807

P. O. Address Kansas City, 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.