

8-43
5-17-39
X37823

State File No. _____

APR JUL 7 1945
Registration District No. _____

Primary Registration District No. 5-122405 1

Registrar's No. _____

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

Ollie May 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
6. (b) Name of husband or wife Frank Turner 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased Dec. 28 1874
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name James Bratton
13. Birthplace don't know 9
(City, town, or county) (State or foreign country)
14. Maiden name Mattie Bragg
15. Birthplace Hallsville Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Jessie Hays
(b) Address Hallsville, Missouri

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hallsville

18. (a) Signature of funeral director E. E. Hopper
(b) Address Clarence, Missouri

19. (a) March 18 1945 (Date received local registrar) Mrs. Leon Burkey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 17
year 1945 hour 10 minute 40 A. M.
21. I hereby certify that I attended the deceased from March 11, 1945, to March 16, 1945;
that I last saw her alive on March 16th, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial degener-
ation Influenza
Due to _____
Due to _____

Duration
3 days
8 days

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

Major findings:
Of operations _____
Of autopsy 93d

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? _____ (Specify type of place) _____
(Specify type of place) _____ Means of injury _____

23. Signature R. P. Roberts (M. D. or other) Do.
Address Centralia, Mo. Date signed 3-17-45

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

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.....

Licensed Embalmer No. *4260*

P. O. Address *Blaineville*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. _____

Registration District No. 40

Primary Registration District No. 4051

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Hallsville
(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 Ollie M 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 M

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec (Month)

28 (Day) 1945 (Year)

8. AGE:

Years 71

Months _____

Days _____

If less than one day

_____ hr. _____ 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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar)

(b) (Ruby West) (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 MO day 7
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him/her _____ 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

S-19838