

FILED DEC 1 1945
Registration District No. **265**

Primary Registration District No. **5896**

Registrar's No. **1**

1. PLACE OF DEATH:

(a) County **Ozark**
(b) City or town **Noble Rural Noble**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 **Sybil Irene Turner**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **September 25, 1945**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 1 hr. _____ min.

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

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **Trellia Troy Turner**

13. Birthplace **Foil, Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Gladya S. Wilkerson**

15. Birthplace **Squires, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Trellia Troy Turner**

(b) Address **Noble Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-27-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Thornfield,**

18. (a) Signature of funeral director **Friends**

(b) Address **Noble, Missouri**

19. (a) **11-17-45** (Date received local Registrar) (b) **MAY Johnson** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Douglas** **34**
(c) City or town **### Noble,**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No) **1**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **26**
year **1945** hour **7** minute **40 A.** M.

21. I hereby certify that I attended the deceased from **Sept 24**
1945 to **Sept 26, 1945**
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Intra Cranial Hemorrhage** **2 yr**

Due to **R.O.A. position**

Due to **difficult delivery**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **1600**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **M. C. Hendry** (M. D. or other) **10-11-45**

Address **one** Date signed **10-11-45**

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..... *W.B. Hutchinson*.....
Licensed Embalmer No. *3431*.....
P. O. Address *Am MD*.....

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.