

S. No. 2
OM-2-43
v. 5-17-39
I X35697

12644

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

State File No. _____

Registrar's No. 92

FILED APR 26 1946 STANDARD CERTIFICATE OF DEATH

Registration District No. 77

Primary Registration District No. 3016

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 740 Forest 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 43 years
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26

(c) City or town Jefferson City 5
(If outside city or town limits, write "RURAL")

(d) Street No. 740 Forest 4
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Jennie Turner

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1946 hour 4 minute 50 M.

21. I hereby certify that I attended the deceased from 10 1946 to April 7 1946 that I last saw her alive on April 7 1946 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased: March 11 1888
(Month) (Day) (Year)

Immediate cause of death: Cerebral hemorrhage Duration 4 days

8. AGE: Years 58 Months 0 Days 26 If less than one day hr. _____ min. _____

Due to Hypertension 6 years

Due to _____

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

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

Major findings: Stroke **PHYSICIAN**

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

10. Usual occupation Housewife

11. Industry or business at home

12. Name Franklin P. Clark

13. Birthplace Uniontown Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Emma Jones

15. Birthplace Uniontown Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant William Turner

(b) Address 740 Forest

17. (a) Burial (b) Date thereof 4-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spring

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 _____ 0

23. Signature H. Kanig... (M. D. or other) M.D.

Address 1 Duellmeyer Bldg Date signed 4/12/46

18. (a) Signature of funeral director Stamm

(b) Address 212 Jefferson

19. (a) 4-17-46 (b) R. P. Overstreet
(Date received local registrar) (Registrar's signature)

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

6
5
4

30
27
11549

Kanagawa

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-25-46

MAY 9 1946

APR 26 1946

JUL 16 1947

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 *Sydney A. White*

Licensed Embalmer No. 4321

P. O. Address *Jefferson 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.