

**FILED JUN 14 1946**

Registration District No. **71**

Primary Registration District No. **3012**

Registrar's No. **41**

1. PLACE OF DEATH:  
(a) County **Clay**  
(b) City or town **Excelsior Springs, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Excelsior Springs Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **39 1/2 hours**  
(Specify whether  
In this community **Same**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Kansas** (b) County **Wyandotte** **999**  
(c) City or town **Kansas City** **14**  
(If outside city or town limits, write "RURAL") **0**  
(d) Street No. **1250 Sandusky**  
(If rural, give location) **2**  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Oscar M. Turner**  
3. (b) If veteran, name war **No.**  
3. (c) Social Security No. **494-14-9292**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **April** day **12th**  
year **1946** hour **2:30** minute **A. M.**

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Mary Turner** 6. (c) Age of husband or wife if alive **61** years  
7. Birth date of deceased **October 24, 1885**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 10, 1946** to **April 12th, 1946**  
that I last saw him alive on **April 12th, 1946**  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>62</b>	<b>5</b>	<b>18</b>	.....hr. ....min.

Immediate cause of death **Internal Injuries & Shock.** Duration **40 1/2 hr**

9. Birthplace **Smith Center, Kansas**  
(City, town, or county) (State or foreign country)

Due to **Auto accident- Apr., 10, 1946**  
**Injured chest, broken & crushed**  
**Due to upper 1/3 rt. femur, severe**  
**laceration of scalp (frontal)**

10. Usual occupation **Truck driver**

Other conditions **None**  
(Include pregnancy within 3 months of death)

11. Industry or business **Pacific Intermountain Express**

22. If death was due to external causes, fill in the following:

12. Name **Frank Turner**

Major findings: **None**  
Of operations.....

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

Of autopsy **None**

14. Maiden name **Lucinda Morgan**

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

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

16. (a) Informant **Mrs Mary J. Turner**

22. (a) Accident, suicide, or homicide (specify) **Auto accident**  
(b) Date of occurrence **April 10, 1946** **24 days**  
(c) Where did injury occur? **4 mi. W of Ex. Sprgs. Cl**  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Public Highway # 69**

(b) Address **1250 Sandusky, K.C., Kansas**

17. (c) **Removal** (b) Date thereof **4/14/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ash Grove, Kansas**

18. (a) Signature of funeral director **Echternacht Funerl Home**  
(b) Address **Kansas City 2, Kansas**

(Specify type of place)  
While at work **Driving truck** means of injury **accident**

19. (a) **4/16/46** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

23. Signature **[Signature]** (M. D. or other) **MD**  
Address **Excelsior Springs, Mo.** Date signed **4/16/46**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-14-46

SEP 30 1947

OCT 3 1947

RECEIVED

JUN 19 1946

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, by.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Harold L. Echterman

Licensed Embalmer No. 3035

P. O. Address. 1900 Central

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.

Kansas City 2, Mo

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Springs  
(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 \_\_\_\_\_ (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 \_\_\_\_\_

3. (a) PRINT FULL NAME Oscar M. Turner

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

4. Sex M 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 \_\_\_\_\_

7. Birth date of deceased Oct 24  
(Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days \_\_\_\_\_  
(less than one day) hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (b) Baroline Hutchings  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence April 10, 1946

(c) Where did injury occur? 4 mi. W. of Ex. Spg. Clay Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, or in public place? Public Highway no. 69

While at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury collision truck & auto

23. Signature S.R. Morsaken (M. D. or other) MD

Address \_\_\_\_\_ Date signed 6/22/46

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

14953

160061