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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 11 1946

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 36696

Registrar's No. 943

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

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 DAYS (Specify whether years, months or days)
In this community 6 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County WRIGHT 114
(c) City or town MANSFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SARAH ELIZABETH DENNIS TURNER

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife CHARLES HEDNIDUS TURNER

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

7. Birth date of deceased OCTOBER (Month) 12 (Day) 1872 (Year)

8. AGE: Years 74 Months 1 Days 11 If less than one day hr. min.

9. Birthplace WRIGHT COUNTY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business OWN HOME

FATHER
12. Name JOHN. W. DENNIS
13. Birthplace ? (City, town, or county) TENNESEE (State or foreign country)

MOTHER
14. Maiden name ELIZABETH BURKE
15. Birthplace ? (City, town, or county) TENNESEE (State or foreign country)

16. (a) Informant CLYDE H. TURNER
(b) Address MANSFIELD, MISSOURI

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26-46 (Month) (Day) (Year)
(c) Place: burial or cremation MANSFIELD CEMETERY

18. (a) Signature of funeral director J. A. Steffe
(b) Address MANSFIELD MO

19. (a) 11-29-46 (Date received local registrar) (b) W. E. Hawley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 23 year 1946 hour 5 minute 10 P.M.

21. I hereby certify that I attended the deceased from DECEMBER 1944 to NOVEMBER 23 1946; that I last saw her alive on NOVEMBER 23 1946; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
ACUTE CONGESTIVE HEART FAILURE	2 DAYS
Due to ACUTE CORONARY OCCLUSION	14 DAYS
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Thomas S. Harris (M. D. or other) MD
Address Medical Arts Bldg. Date signed 11/23/46
Springfield, Mo

111 (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 F. A. Steffe

Licensed Embalmer No. 3221

P. O. Address Mansfield 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.