

7. S. No. 2
FORM-5-42
Rev. 5-17-39
I X32873

39539

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 15

FILED JAN 7 1947

Registration District No. _____
Primary Registration District No. 4021

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

1. PLACE OF DEATH:

(a) County AUDRAIN.

(b) City or town LADDONIA-MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: LADDONIA-MO.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 33 YRS. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County AUDRAIN

(c) City or town LADDONIA-MO.
(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 WALTER C. TURNER.

3. (b) If veteran, name war _____

3. (c) Social Security No. NONE.

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife COLEA-TURNER

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased AUG-9-1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

64 4 19 hr. _____ min.

9. Birthplace MONROE, CO. MO.
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER.

11. Industry or business LABOR.

12. Name ISAC-N-TURNER.

13. Birthplace UNKNOWN MO.
(City, town, or county) (State or foreign country)

14. Maiden name JANE-HOLDER.

15. Birthplace UNKNOWN MO.
(City, town, or county) (State or foreign country)

16. (a) Informant Colea Turner.

(b) Address LADDONIA-MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC-31-46
(Month) (Day) (Year)

(c) Place: burial or cremation LADDONIA-MO.

18. (a) Signature of funeral director Clyde Wilkey

(b) Address LADDONIA-MO

19. (a) 12-31-46 (Date received local registrar) (b) Martha Kuenen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 29 year 1946 hour 10:30 minute P. M.

21. I hereby certify that I attended the deceased from Nov 6, 1946 to Dec 28, 1946 that I last saw him alive on Dec 28, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to _____

Due to _____

Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Major findings:
Of operations W
Of autopsy _____

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

23. Signature R. B. Baize (M.D. or other D.O.)
Address LADDONIA-MO Date signed 1/7/47

Duration

1 hr.

2 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

FEB 4 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 Clyde Wilkey
Licensed Embalmer No. 3820
P. O. Address Perry, Ind

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.