

FILED JAN 29 1947

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Ninty-one days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ozark
(c) City or town Squires
(If outside city or town limits, write "RURAL")
(d) Street No. Star Route
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Turner, Earl

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Icy Turner 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased: March 3, 1900
(Month) (Day) (Year)

8. AGE: Years 46 Months 9 Days 29 If less than one day
hr. _____ min.

9. Birthplace Douglass County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Jess Turner
13. Birthplace ?
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name _____
15. Birthplace ?
(City, town, or county) (State or foreign country)

16. (a) Informant Icy Turner
(b) Address Squires, Mo.

17. (a) Removal (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director Parsons Fun S
(b) Address Columbia Mo

19. (a) Jan 2 47 (b) Mrs. R E Palmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1
year 1947 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from October 2, 1946 to January 1, 1947
that I last saw him alive on January 1, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Mycobacterium tuberculosis
Due to _____

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

Major findings: Of operations
Of autopsy _____
PHYSICIAN _____

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 J. J. McQuinn (M. D. or other) M.D.
Address Cancer Hospital Columbia Mo. Date signed 1/1/47

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

JAN 14 1947
File Number

RECEIVED
District Health Officer No. 9

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..... *M. W. Whitesides*

Licensed Embalmer No. *3893*

P. O. Address..... *Columbia, 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.