S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27974

Registration District No. FILED AUG 19 1947

Primary Registration District No. 1002

Registrar's No. 3413

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Jordan Rest Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 months in (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~Jackson~~ Clay 24

(c) City or town Avondale 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Emily A. TURNER

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Isom Turner

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased September (Month) 18, (Day) 1873 (Year)

8. AGE: Years 73 | Months ~~9~~ 10 | Days 20 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business At home

FATHER
12. Name Samuel B. Tanner
13. Birthplace Appomattox Co., Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Judith R. White
15. Birthplace Ray County, Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Eugene Turner
(b) Address Clay County, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-11-47 (Month) (Day) (Year)
(c) Place: burial or cremation Orrick, Missouri

18. (a) Signature of funeral director Mellody-McGilley-Eylar
(b) Address Kansas City, Mo.

19. (a) 8-9-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8
year 1947 hour 2 minute 10 P. M.

21. I hereby certify that I attended the deceased from 7-21-46 ....., 19....., to death ....., 19.....;
that I last saw her alive on 6-15-47, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 97

Of autopsy

Duration

PHYSICIAN

Underline the cause of 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 0

23. Signature R. H. Dunham (M. D. or other)

Address Nile, Mo Date signed 8/9/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Dr. R. R. Dunham

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 Glen E. Heck

Licensed Embalmer No. 4063

P. O. Address K. C. 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.

S. No. 2B
5M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 34/3

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

1. PLACE OF DEATH:

(a) County .....

(b) City or town ..... (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 years, months or days) In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clay

(c) City or town Avondale (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 Emily A. Turner

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex .....

5. Color or race .....

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

6. (b) Name of husband or wife .....

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

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

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

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

16. (a) Informant .....
(b) Address .....

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

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 8-9-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 8 year 1947 hour 10 minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19.....; that I last saw h. ..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death ..... *Duration*

Due to .....

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 ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

S-279911