. No. 2
—12-45
5-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 26 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7855

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 5

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Centralia
(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 35 YRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Boone 10
(c) City or town Centralia 1
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Miss Lear 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 Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec. (Month) 25 (Day) 1882 (Year)

8. AGE: Years	Months	Days	If less than one day
65	2	16	hr. min.

9. Birthplace Pyatt Co. Ill (City, town, or county) 1 (State or foreign country)
10. Usual occupation House Keeper
11. Industry or business
FATHER
12. Name H. F. Turner
13. Birthplace Boone Co. Mo. (City, town, or county) 0 (State or foreign country)
MOTHER
14. Maiden name Matilda Jones
15. Birthplace D. Ohio (City, town, or county) 1 (State or foreign country)
16. (a) Informant Miss Katharine Turner
(b) Address Centralia
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-48 (Month) (Day) (Year)
(c) Place: burial or cremation Cemetary, Centralia
18. (a) Signature of funeral director Geo. Jernigan
(b) Address Centralia Missouri
19. (a) March 20/48 (Date received local registrar) (b) Maud McBride (Registrar's signature) 30

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11 year 1948 hour 3 minute A.M.
21. I hereby certify that I attended the deceased from Aug. 18, 1945, to Mar. 10, 1948 that I last saw her alive on March 10, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	15 hours
Due to: Arterial hypertension	3 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

83 X

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? 0
(Specify type of place)
While at work? (e) Means of injury

23. Signature L. Lachance (M. D. or other) M.D
Address Centralia, Mo Date signed 3-13-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed MAR 25 1948

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 Grover Jernigan

Licensed Embalmer No. 4270

P. O. Address Centralia, 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.