

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42233

FILED DEC 16 1948

Registration District No. 349

Primary Registration District No. 6180

Registrar's No. 4

1. PLACE OF DEATH:  
(a) County Sullivan  
(b) City or town Winigan - Morris Twp.  
(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 1  
In this community Lifetime  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Sullivan 105  
(c) City or town Winigan  
(If outside city or town limits, write "RURAL") 0  
(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 William Turner  
(b) If veteran, name war ✓  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 26  
year 1948 hour 3 minute 45 A.M.

4. Sex M 5. Color or race 0  
6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Maggie Patrick Turner  
6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased: June 7, 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1940 to Nov. 23, 1948  
that I last saw him alive on Nov. 23  
and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 5 Days 19  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Cerebral hemorrhage  
Duration 4da

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

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death)  
Major findings: g36

11. Industry or business \_\_\_\_\_

Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Joseph B. Turner  
13. Birthplace Ind.  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Noble W Turner  
(b) Address Brookfield Mo.

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof Nov 28, 48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Winigan, Mo.

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

18. (a) Signature of funeral director Glenn E. Ford & Son  
(b) Address Green City Missouri  
19. (a) 12-11-48 (b) Laura Cattle  
(Date received local registrar) (Registrar's signature) 4/5

23. Signature J. R. McArthur (M. D. or other) \_\_\_\_\_  
Address Browning Mo Date signed 12/24/48

48. (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 1

District File Number 12-48-26

Date Filed DEC-13-1948

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.....

Karl R Kent

....., Registered Apprentice No. 243

working under my personal supervision.

Signed Archie W Wade

Licensed Embalmer No. 3037

- P. O. Address Green City 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.

2B  
45  
4388D

State File No. Jan  
Registrar's No. 4

Registration District No. 349

Primary Registration District No. 6180

1. PLACE OF DEATH

(a) County Dellwan

(b) City or town Wenigan  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Wm Turner

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

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

4. Sex M 5. Color or race White

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

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

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

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

8. AGE: Years 78 Months 5 Days 9  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Dec-11-48 (b) Laura Collett  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
Year 1948 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ 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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

5-42283