

FILED FEB 7 1949

STANDARD CERTIFICATE OF DEATH

State File No. 1125

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <u>Nowell</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Bakersfield</u> b. COUNTY <u>Barstow</u>		
b. CITY OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <u>Bakersfield, Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>✓</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Meadow Rest Home</u>					

3. NAME OF DECEASED (Type or Print) <u>Mrs. Jno. S. Turner</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1 12 49</u>		
a. (First)	b. (Middle)	c. (Last)			

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>1-15-1869</u>	9. AGE (In years last birthday) <u>80 11 20</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 Hrs. Min.
-----------------	---------------------------	---	-----------------------------------	---	------------------------	----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>Covey, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	--	--	--	--	---

13a. FATHER'S NAME <u>Jno. Turner</u>	13b. MOTHER'S MAIDEN NAME <u>unk</u>	13c. NAME OF HUSBAND OR WIFE <u>Anna Turner</u>		
---------------------------------------	--------------------------------------	---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clifford Turner, Oakley, Ill</u>		
--	----------------------------------	---	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Decease</u>	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>124's</u>			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Chronic Arthritis with Deformity</u>			
	DUE TO (b)			
	DUE TO (c)			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	--	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from Dec 10, 1948 to Jan 12, 1949, that I last saw the deceased alive on Jan 4, 1949, and that death occurred at 12:40 m., from the causes and on the date stated above.

23a. SIGNATURE (Disease or title) <u>Beatrice Cook</u>	23b. ADDRESS <u>West Plains, Mo</u>	23c. DATE SIGNED <u>1-17-49</u>
--	-------------------------------------	---------------------------------

24a. BURIAL CREMATION, REMOVAL (Specify)	24b. DATE <u>1-12-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Newkirk Ridge</u>	24d. LOCATION (City, town, or county) (State) <u>Bakersfield Mo</u>
--	--------------------------	---	---

DATE REC'D BY LOCAL REG. <u>Jan 27-49</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> 379	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Koblerman West Plains Mo</u>
---	--	--

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

46
1

RECEIVED 2-2-49
District Health Officer No. 5
District File Number 24912
Date Filed 2-2-49

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 _____

_____ Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed *D. D. Robertson*

Licensed Embalmer No. 3437

P. O. Address West Plains, 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.