

FILED NOV 9 1949

State File No. \_\_\_\_\_

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

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>268</u>		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
a. COUNTY <u>Boone</u>		b. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Boone</u>		
c. LENGTH OF STAY (In this place) <u>3 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>		d. STREET ADDRESS (If rural, give location) <u>LA Watson Place</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>LA Watson Place</u>				
3. NAME OF DECEASED			4. DATE OF DEATH					
a. (First) <u>ELLA</u>		b. (Middle) <u>LELAND</u>		c. (Last) <u>TURNER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 29, 1949</u>		
(Type or Print)								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 19, 1870</u>		
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Lexington, Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13a. FATHER'S NAME <u>John J. Snider</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Zink</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel A. Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. R.B. Deering, Columbia, Mo.</u>				
18. CAUSE OF DEATH		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>mesenteric thrombosis</u>					<u>2 days</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					<u>probably 10 years</u>	
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					<u>5702</u>	
		DUE TO (b) <u>mitral valvulitis, arteriosclerosis</u>					<u>3 years</u>	
		DUE TO (c) <u>Essential hypertension</u>						
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		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 <u>Oct 8, 1949</u> , to <u>Oct 30, 1949</u> , that I last saw the deceased alive on <u>Oct 29, 1949</u> and that death occurred at <u>11:40 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>James D. Allen M.D.</u>				23b. ADDRESS <u>Columbia Mo</u>		23c. DATE SIGNED <u>10-30-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 1, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Carrolton, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>Nov 1 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>31 0 Parker Funeral Service, Columbia, Mo</u>				

District File Number  
District Health Officer No. 9  
RECEIVED  
NOV 7 1919

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 *M. D. White* .....

Licensed Embalmer No. *3893* .....

P. O. Address *Columbus Miss* .....

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.