

FILED NOV 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36321**

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 282

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 town) <u>Columbia</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Boone</u>
c. LENGTH OF STAY (In this place) <u>1 Hour</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>	d. STREET ADDRESS (If rural, give location) <u>1509 Ross St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)
a. (First) <u>ANNA</u>	b. (Middle) <u>ALVIRA</u>	c. (Last) <u>TURNER</u>	<u>Nov. 14, 1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 5, 1894</u>
9. AGE (In years last birthday) <u>55</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Menasha, Wisconsin</u>
10a.		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>John Schartz</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Long</u>	14. NAME OF HUSBAND OR WIFE <u>Charles W. 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>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles W. Turner, Columbia, Mo.</u>
18. CAUSE OF DEATH			
Enter only one cause per line for (a), (b), and (c)			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
ANTECEDENT CAUSES		DUE TO (b) <u>Hypertension</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS		<u>31X</u>	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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>Sept 25, 1949, to Nov. 14, 1949</u> that I last saw the deceased alive on <u>Nov. 14, 1949</u> and that death occurred at <u>11:45</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>E. S. Baskett M.D.</u>		23b. ADDRESS <u>Columbia Mo</u>	
		23c. DATE SIGNED <u>11/14/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 18, 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 16, 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	
		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parker Funeral Service, Columbia Mo.</u>	

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

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MAR 17 1950

RECEIVED 11-21-49
District Health Officer No. 97

JUN 2 1950

MAY 21 1954

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.

Signed: Tom M. Harg

Signed.....
Student Embalmer

Licensed Embalmer No. 5067

P. O. Address Columbia, 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.