

FILED DEC 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37827

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

| | | | | | | | | |
|--|------------------------------|--|--|--|---------------------------------------|---|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>10/2</u> | | PRIMARY REG. DIST. NO. <u>5637</u> | | Registrar's No. <u>4</u> | | |
| 1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lafayette</u> | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Napoleon - Rural</u> | | c. LENGTH OF STAY (in this place) <u>50 yrs</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Napoleon - Rural</u> | | d. STREET ADDRESS (If rural, give location) <u>5 mi North</u> | | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>5 mi North</u> | | | | d. STREET ADDRESS (If rural, give location) <u>5 mi North</u> | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Wm</u> b. (Middle) <u>Joseph</u> c. (Last) <u>Turner</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 20-1949</u> | | | | | |
| 5. SEX <u>MA</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Jan 26-1861</u> | 9. AGE (In years last birthday) <u>88</u> | IF UNDER 1 YEAR Months <u>8</u> | IF UNDER 1 YEAR Days <u>25</u> | IF UNDER 1 HR. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Lafayette Co. Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13a. FATHER'S NAME <u>James L Turner</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary E Hufford</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mary Jane</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>Mary J Turner Napoleon Mo</u> | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Heart attack from nuclear neuropathy</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>29.5X</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 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 <input type="checkbox"/> 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>10/19/49</u> , 19 <u>49</u> , to <u>10/20/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10/19/49</u> , 19 <u>49</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>W B Webb M.D.</u> | | | | 23b. ADDRESS <u>Odeosa Mo</u> | | 23c. DATE SIGNED <u>10/21/49</u> | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u> | | 24b. DATE <u>10-21-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u> | | 24d. LOCATION (City, town, or county) (State) <u>Oak Grove Mo</u> | | |
| DATE REC'D BY LOCAL REG. <u>10/21/1949</u> | | REGISTRAR'S SIGNATURE <u>Letta Drummond</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs G B Webb Son</u> | | ADDRESS <u>Oak Grove Mo</u> | | |

RECEIVED NOV 30
District Health Officer No. 8.
District File Number.....
Date Filed 12-2-49

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 RB Webb

Licensed Embalmer No. 2353

P. O. Address Blue Springs

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.