

FILED JUL 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19619

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 2114

1. PLACE OF DEATH a. COUNTY CAPE GIRARDEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) CAPE GIRARDEAU		c. CITY (If outside corporate limits, write RURAL and give township) PERKINS.	
c. LENGTH OF STAY (in this place) 3 DAYS		1000	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST FRANCIS HOSPITAL		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print)	a. (First) GEORGE	b. (Middle) WASHINGTON	c. (Last) TURNER	4. DATE OF DEATH (Month) (Day) (Year)	JULY 3 1950
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Nov 9 1865	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) NEAR NASHVILLE, TENN	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME OS TURNER	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE TURNER MARY EUGENIA BETH FOISTER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Roy Turner	ADDRESS Perkins, Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension		
	DUE TO (c)		
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 type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from July 1st 1950, to July 2nd 1950, that I last saw the deceased alive on July 3, 1950; and that death occurred at 6 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]	23b. ADDRESS [Address]	23c. DATE SIGNED 7/6/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 6 1950	24c. NAME OF CEMETERY OR CREMATORY FRIENDS	24d. LOCATION (City, town, or county) (State) ORAN MISSOURI
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DATE REC'D BY LOCAL REG. 7-6-1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS [Address]
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2160

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 Oliver O. Smith

Licensed Embalmer No. 4470

P. O. Address Olms, 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.