S. No. 300
10.48

FILED SEP 13 1950

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

27437

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 179 PRIMARY REG. DIST. NO. 4287 Registrar's No. 35

1. PLACE OF DEATH
a. COUNTY Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
c. LENGTH OF STAY (in this place) 32 yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) JESSIE b. (Middle) M c. (Last) TURNBULL

4. DATE OF DEATH (Month) (Day) (Year) 8-28-1950

5. SEX F
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug 6 1884
9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months 0 Days 22 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME George Jackson
13b. MOTHER'S MAIDEN NAME Ellen Bray
14. NAME OF HUSBAND OR WIFE Riley Turnbull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Riley Turnbull ADDRESS Troy Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Bronchial Asthma
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

241X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* Aug 28, 1950, *that I last saw the deceased alive on _____ 19__, and that death occurred at* 10:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE J. C. Cuerch (Degree or title) MD
23b. ADDRESS Troy Mo
23c. DATE SIGNED Aug 30/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-30-50
24c. NAME OF CEMETERY OR CREMATORY Bray Cemetery
24d. LOCATION (City, town, or county) (State) Lincoln County Mo

DATE REC'D BY LOCAL REG. 9-8-1950
REGISTRAR'S SIGNATURE Emma B. Riddle 162
25. FUNERAL DIRECTOR'S SIGNATURE Wayne McCoy ADDRESS Troy Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
SEP - 7 1950
DISTRICT HEALTH OFFICE No. 4
File No. .....

MAR 28 1951

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 .....

working under my personal supervision.

Student Embalmer No. .....

Signed Wayne McCoy

Signed .....
Student Embalmer

Licensed Embalmer No. 3584

P. O. Address Troy 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.