No. 300
10.48

0460 1

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28457

FILED AUG 24 1953

BIRTH NO. _____ REG. DIST. NO. 142 PRIMARY REG. DIST. NO. 4557 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pomona R.F.D.
c. LENGTH OF STAY (in this place): 69
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: Howell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 0460
d. STREET ADDRESS (If rural, give location): Pomona R.F.D. 0

3. NAME OF DECEASED (Type or Print)
a. (First): Mack
b. (Middle): Thurman
c. (Last): Turner

4. DATE OF DEATH (Month) (Day) (Year): 7-28-1953

5. SEX: M. 0
6. COLOR OR RACE: Wht.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M.
8. DATE OF BIRTH: Apr 13 1884
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months 3, Days 15 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Railroadworker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Alden Mo. 0
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Doctor T Turner
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: Minnie Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: yes
17. INFORMANT'S SIGNATURE OR NAME: Minnie Turner — ADDRESS: Pomona R.F.D.

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema, Acute — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congestive Heart Failure — 3 months

DUE TO (c) Arteriosclerotic Heart Dis — ?

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: 4200
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 3-5, 1953, to 7-28, 1953 that I last saw the deceased alive on 7-28, 1953, and that death occurred at 5:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Jack N. Wilks MD
23b. ADDRESS: West Plains, Mo
23c. DATE SIGNED: 8-17-53

24a. BURIAL, CREMATION, REMOVAL (Specify): B
24b. DATE: Aug 2 1953
24c. NAME OF CEMETERY OR CREMATORY: Mt Zion
24d. LOCATION (City, town, or county) (State): Pomona Mo. R.F.D.

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: Clyde J. Bridges
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robertson's West Plains Mo.

(Licensed Embalmer's Statement on Reverse Side)

APR 18 1956

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 D. A. Lakerson

Licensed Embalmer No. 3432

P. O. Address .....

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.