

FILED JAN 5 1954

STANDARD CERTIFICATE OF DEATH

State File No. 43339 Registrar's No. 225

BIRTH NO. REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Boone	
b. CITY OR TOWN Rural Prairie		c. CITY OR TOWN Rural Pershe Twp 0100	
c. LENGTH OF STAY (In this place township) 1 Week		d. STREET ADDRESS (If rural, give location) 4 1/2 mi West Columbia Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5 mi SW Lees Summit			

3. NAME OF DECEASED (Type or Print) Marcus Jones Turner			4. DATE OF DEATH (Month) (Day) (Year) 12-14-53		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH Mar. 12-1871	9. AGE (In years last birthday) 82	10. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Columbia Mo	

12a. FATHER'S NAME James Turner		12b. MOTHER'S MAIDEN NAME Elizabeth Dozier		12c. NAME OF WIFE OR WIFE Josephine Turner	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		14. SOCIAL SECURITY NO.		15. INFORMANT'S SIGNATURE OR NAME James Turner	
				ADDRESS Lees Summit 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) chronic hypertension DUE TO (c) old age II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis 443 X		INTERVAL BETWEEN ONSET AND DEATH several months	
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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)		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 Dec. 5, 1953, to Dec. 14, 1953, that I last saw the deceased alive on Dec. 10, 1953, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Ralph A. Powell D.C.		23b. ADDRESS 108 East 6th Lees Summit		23c. DATE SIGNED Dec. 15, 1953	
24a. BURIAL CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/17/53		24c. NAME OF CEMETERY OR CREMATORY Memorial Park	
24d. LOCATION (City, town, or county) Columbia Mo		24e. (State)			
DATE REC'D BY LOCAL REG. 12/15/53		REGISTRAR'S SIGNATURE W.B. Langford 483		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.B. Langford Lees Summit Mo	

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

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 N. B. Longford
Licensed Embalmer No. 3823
P. O. Address Lee's Summit

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.