

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 3 - 1955

30022

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>104</u>		PRIMARY REG. DIST. NO. <u>3037</u>		Registrar's No. <u>100</u>		
1. PLACE OF DEATH a. COUNTY <u>Johnson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrensburg;</u>		c. LENGTH OF STAY (in this place) <u>20 yrs.</u>		c. CITY OR TOWN <u>Warrensburg,</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Residence, 414 W. Market St.</u>				No. STREET ADDRESS (If rural, give location) <u>414 West Market St.</u> 05120				
3. NAME OF DECEASED (Type or Print) <u>WILANN SMITH FORBUSH TURNER</u>			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <u>Sept. 18th. 1955</u>				4. DATE (Month) (Day) (Year)				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 3rd. 1917</u>		
9. AGE (In years last birthday) <u>38</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Higgensville, Missouri</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Pete Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Pearl Russell</u>		14. NAME OF HUSBAND OR WIFE <u>Meralin Turner</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>490-18-5343</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Pearl Hall, Higgensville, Missouri</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>Multiple arterial emboli with occlusions</u>				INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>		
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Auricular fibrillation</u>				<u>3 years</u>		
		DUE TO (c) <u>Rheumatic heart disease</u>				<u>Known 3 years</u>		
		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"/>		
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 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>August 4, 1953</u> , to <u>9-18-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-18-</u> , 19 <u>55</u> , and that death occurred at <u>7:25A m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Keith D. Jones M.D.</u>				23b. ADDRESS <u>Warrensburg, Missouri</u>		23c. DATE SIGNED <u>9-20-1955</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-21-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cemetery,</u>		24d. LOCATION (City, town, or county) (State) <u>Warrensburg, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>Sept. 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Savannah C. [unclear]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Brauninger, Warrensburg, Mo.</u>				

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

SEP 26 1955

RECEIVED
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RECEIVED

JOHNSON COUNTY HEALTH DEPT.

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 [Signature]....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
[Signature]

Licensed Embalmer No...33...

P. O. Address...[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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.