

**FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 044713

FILED VS JAN - 8 1960

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 304a Registrar's No. 2

RECEIVED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Livingston</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Linn</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe, Mo.</b>		Length of stay in 1b <i>unknown</i>		c. CITY OR TOWN <b>Browning, Mo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Miller Rest Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mattie</b> Middle _____ Last <b>Turner</b>				<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>29</b> Year <b>59</b>									
<b>5. SEX</b> <b>Fe</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4/22/1871</b>		<b>9. AGE (last birthday)</b> <b>88</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housewife</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>					
<b>13a. FATHER'S NAME</b> <b>Thomas Moffett</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Jennings</b>				<b>14. NAME OF HUSBAND OR WIFE</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <b>Junius M Buxton</b>				Address <b>Chicago Ill.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>8 wks</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>arteriosclerosis generalized with arteriosclerotic heart disease</b>										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____		STATE _____					
<b>21. I attended the deceased from</b> <u>July 19 59</u> to <u>Dec 29, 1959</u> and last saw her <u>live</u> on <u>Dec 19, 1959</u> Death occurred at <u>5:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <b>William L. Fair, M.D.</b>					<b>22b. ADDRESS</b> <b>Chillicothe, Mo</b>					<b>22c. DATE SIGNED</b> <b>12/31/59</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>1/1/60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Jenkins Cem</b>		<b>23d. LOCATION</b> (City, town, or county) <b>Browning Rural Mo.</b>							
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Wade Funeral Home</b> <b>Browning Mo</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>12/31/59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Francis B. Neill</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 14 1960

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Gerald T. Wadsworth

Licensed Embalmer No. 4170

P. O. Address Brown

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.