

REC'D SEP 15 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29966
Do not use this space.

1. PLACE OF DEATH
 (a) County Pike Registration District No. 688
 (b) Township Pena Primary Registration District No. 5916 Registered No. 13
 (c) City _____ (d) Street No. RFD Frankford Mo St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James Turner
 (a) Residence, No. RFD Frankford Mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/13-39
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 0 4 7
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
 9. Industry or business in which work was done, as saw mill, bank, etc. Child
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) RFD - Frankford Mo
 FATHER 13. NAME Eugene Turner
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisiana Mo
 MOTHER 15. MAIDEN NAME Georgie Redmond
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gray Mo
 17. INFORMANT (ADDRESS) Eugene Turner RFD Louisiana Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Greenwood - Louisiana Mo 7/29 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gotchaugh Louisiana Mo
 20. FILED Sept 8 - 1939 Mattie Urnell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-19 39
 22. I HEREBY CERTIFY, That I attended deceased from May 9 1934 to July 19 1939
 I last saw him alive on June 18 1939. Death is said to have occurred on the date stated above, at 8:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Spina Aifida
 Date of onset _____
 Other contributory causes of importance: 157 lb
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) O. H. [Signature], M. D.
 (Address) Frankford Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 10

District File Number 9-39-1589

Date Filed SEP 11 1939

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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, above space should be left blank.