

31572

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

330 OCT 18 1939

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3620

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. Gen. Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether _____)
In this community 3 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2039 Bellview
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME Turner Infant 656

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 8 1939
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>3</u>	hr. _____ min.

9. Birthplace K.C. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name James Turner
13. Birthplace Ks. 1
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Kelley
15. Birthplace Ks
(City, town, or county) (State or foreign country)

18. (a) Informant's own signature Diana Cleve
(b) Address K.C. Gen. Hosp K.C. Mo

17. (a) Burial (b) Date thereof 9-20-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lead.
18. (a) Signature of funeral director Wm. A. Johnson
(b) Address 16 E. Gen. Hosp

19. (a) Sept 19 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11
year 1939 hour 1 minute 45 P M.

21. I hereby certify that I attended the deceased from Sept 8, 1939, to Sept 11, 1939
that I last saw him alive on Sept 11, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Deterius Nematocium

Due to _____
Due to 161 B

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy S. e. a. h. v. e.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature J. DeMarr (M. D. or other)
Address Sup. K.C. Gen. Hosp Date signed 9 19 39

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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

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.

1 X19511

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.