

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

35509
Do not use this space.

1. PLACE OF DEATH *85*

(a) County *Buchanan* Registration District No. *1004*

(b) Township *St Joseph* Primary Registration District No. *West Mo. Arz.*

(c) City *St Joseph* (d) Street No. *109 1/2 West Mo. Arz.* Registered No. *1023*

(e) Length of residence in city or town where death occurred yrs. mos. ds. *10* How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *James Turner, Sr*

(a) Residence, No. *109 1/2 West Mo. Arz.* (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*

4. COLOR OR RACE *W. prso.*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Married*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 1st 1876*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *63- 4 7*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired farmer*

9. Industry or business in which work was done, as saw mill, bank, etc. *" "*

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) *Apata Buchanan Co, MO*

FATHER

13. NAME *Peter Turner*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *mid Co Ky.*

MOTHER

15. MAIDEN NAME *Hannah France*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *mid Co Ky.*

17. INFORMANT (ADDRESS) *James Turner Jr 614 Campbell St N. C. Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *King Hill* DATE *Oct. 11 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Bannoy, Max 1602 Medwin St*

20. FILED *10/11 1939* *J. H. Nettles* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 8 1939*

I HEREBY CERTIFY, That I attended deceased *June 1 1939*

I last saw him alive on *Oct 8 1939* Death is said to have occurred on the date stated above, at *12:45 pm*.

The principal cause of death and related causes of importance were as follows:

chronic mitral Insufficiency

Other contributory causes of importance: *not any*

Name of operation *none* Date of *no*

What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? *no* Date of injury *no*

Where did injury occur? *no* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *no*

Nature of injury *no*

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify *no*

(Signed) *Fenton H. Houdsall* M. D.

(Address) *109 1/2 W. Mo. Arz.*

MARGIN RESERVED FOR BINDING

V. S. NO. 2.
50M-9-19-38
I X16605

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

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 J. F. Ramsey
Licensed Embalmer No. 4081
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.