

Registration District No. 743

Primary Registration District No. 6237

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Ray
 (b) City or town Rural - Fishing River
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 02
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution -
 (Specify whether
 In this community all his life
 years, months or days)

3. (a) PRINT FULL NAME

Mary C Turner 656

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married,
divorced Widow

6. (b) Name of husband or wife Turner Deceased

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

7. Birth date of deceased 12
(Month)

7 1866
(Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>10</u>	<u>26</u>	hr. _____ min.

9. Birthplace Ray Co Missouri
(City, town, or county)

(State or foreign country) 0

10. Usual occupation Housewife

0

11. Industry or business none

0

12. Name Simon Hutchings

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Nancy DIXON

15. Birthplace Platte Co Missouri
(City, town, or county) (State or foreign country)

16. Informant's own signature Kenneth McAfee

(b) Address Excelsior Springs, Mo.

17. (a) Burial (b) Date thereof Nov 5 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seagal Crest

18. (a) Signature of funeral director W. Gibson

(b) Address Cruch Mo

19. (a) Nov 8 (b) W. Gibson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 10 miles N.W. Orrick, Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3
 year 1939 hour 9 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw her alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration Just

Due to 94 hr

Other conditions Advanced Arterio-
(Include pregnancy within 3 months of death)

Major findings: Sclerosis
Of operations _____

Of autopsy _____

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. Gaines (M. D. examiner)
 Address Richmond Cora Date signed 11-3-39

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.....

C. W. Libson

Licensed Embalmer No. *2299*

P. O. Address *Oriskany, Mo*

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.