

Registration District No. 460

Primary Registration District No. 4273

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Dover
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life years, months or days

3. (a) PRINT FULL NAME MARY EDNA TURMAN

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

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Tom Turman 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 24 1956
(Month) (Day) (Year)

8. AGE: Years 83 Months 3 Days 21 If less than one day hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Ben Vaughan
13. Birthplace Frankford Va
(City, town, or county) (State or foreign country)
14. Maiden name Anna Taylor
15. Birthplace Norfolk Va
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Blanch Saunders

(b) Address Dover Mo

17. (a) Burial (b) Date thereof Feb. 16 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dover, Mo

18. (a) Signature of funeral director Winkles

(b) Address Lima, Mo

19. (a) Feb 29-40 (b) Tiffany Webb
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15
year 1940 hour 3 minute 10 A. M.

21. I hereby certify that I attended the deceased from 7 Feb.
8 Feb. 1940, to Feb. 14 1940,
that I last saw her alive on Feb. 14 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 wks.
Hypertensive heart disease

Due to hypertension

Due to 95%

Other conditions (Include pregnancy within months of death)
Arteriosclerosis

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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? _____

(Specify type of place) (e) Means of injury _____

23. Signature J. S. Cape (M. D. or other) MD

Address Lexington, Mo. Date signed 2/27/40

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

FORM 1-1935

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
Public Health Officer No. 8
License File Number 3/5/40
Date Filed

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 *Garret J. Tempel*

Licensed Embalmer No. 3275-1

P. O. Address *Lexington, Va*

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.