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10-39
7-39
X21492

State File No. _____

JUL 12 1940
Registration District No. _____

Primary Registration District No. 5036

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Rural - Saling
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9
In this community all of life
years, months or days 1-1

3. (a) PRINT FULL NAME Missie Turner
3. (b) If veteran, name war L
3. (c) Social Security No. None

4. Sex FF 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. - 12 - 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 20
If less than one day _____ hr. _____ min.

9. Birthplace Boone Co. Mo - 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Marshall Hendon
13. Birthplace Mo.
14. Maiden name Kate Angell
15. Birthplace Mo.

16. (a) Informant Mrs. Frank Dean
(b) Address Centralia, Mo.

17. (a) Burial (b) Date thereof June 4 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Pisgah

18. (a) Signature of funeral director Barber & Booth
(b) Address Sturgeon, Mo.

19. (a) June 3 - 1940 (b) Al Bortha
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 2 day 1940
year 1940 hour 9:00 minute P. M.

21. I hereby certify that I attended the deceased from June 2
1940, to June 2 1940
that I last saw her alive on June 2 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage Duration 6 hrs.
Due to Cardio-Vascular
renal Disease

Other conditions 71
(Include pregnancy within 3 months of death)

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?
905 (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Frank W. Barber (M. D. or other) _____
Address Centralia Date signed 6/2/40

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

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. E. Boothe

Licensed Embalmer No. 4087

P. O. Address Sturgeon, 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.