FILED SEP 24 1940

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29823

Registration District No. 815 Primary Registration District No. 6064 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Scott Sandy Trap

(b) City or town SW of Blodgit
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No (Specify whether
In this community 1½ Mounth
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town S/W of Blodgit
(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.

3. (a) PRINT FULL NAME J. F. TURNER 656

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race Colored

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

6. (b) Name of husband or wife No

6. (c) Age of husband or wife if alive No years

7. Birth date of deceased March (Month) 8 (Day) 1940 (Year)

8. AGE: Years | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace CATRON (City, town, or county) No (State or foreign country)

10. Usual occupation Child

11. Industry or business No

FATHER
12. Name JOE TURNER
13. Birthplace UNK. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name LUCILE MILLER
15. Birthplace No (City, town, or county) ARK. (State or foreign country)

16. (a) Informant C. L. HALL
(b) Address SIKESTON, MO R.2-Bx 130

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug (Month) 1 (Day) 1940 (Year)
(c) Place: burial or cremation CATRON

18. (a) Signature of funeral director No
(b) Address No

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1940 hour 5 minute 2 M.

21. I hereby certify that I attended the deceased from July 29, 1940 to only 1, 19 ;
that I last saw him alive on July 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Ac. Colitis — Duration 2 weeks

Due to 119 B

Due to

Other conditions Malnutrition & Dehydration
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Thos. C. McClure (M. D. or other)
Address Sikeston, Mo Date signed 8-2-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No
District File Number 940-14
Date Filed 9/11/4

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-2-21-40
I -X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29823

Registration District No. 815 Primary Registration District No. 6064 Registrar's No.

1. PLACE OF DEATH:
(a) County: Scott
(b) ~~City or town~~ Sandywood T.P
(If outside city or town limits, write "RURAL" and name of township)
(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: Died here not moved obtained further medical attention
In this community (Specify Whether years, months or days) U

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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.

3. (a) PRINT FULL NAME: Joel F Turner
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: Col
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years | Months: 5 | Days: 21 | If less than one day: hr. min.
9. Birthplace: Catron (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name: Joe Turner
13. Birthplace: (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name: Lucy Miller
15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: C. L. Hall
(b) Address: Sikeston
17. (a) (Burial, cremation, or removal) (b) Date thereof: Aug 1-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Catron
18. (a) Signature of funeral director
(b) Address
19. (a) 12/25/40 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Thos C McClure (M. D. or other)
Address: Sikeston Mo. Date signed

SUPPLEMENTARY