S. No. [illegible]
[illegible]
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE [illegible]

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36008

Registration District No. [illegible] NOV 20 1940 Primary Registration District No. 3032 Registrar's No. 323

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

80
4
4

1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 412 N. Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pettis
(c) City or town Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No. 412 N. Wash. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME LAURA MARIE TURNER
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race negro
6. (a) Single, ~~widowed, married, divorced~~
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 23 (Day) 1940 (Year)

8. AGE: Years | Months 87 | Days 11 | If less than one day hr. min.

9. Birthplace Sedalia (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation 0
11. Industry or business 0

MOTHER FATHER
12. Name Noble Turner
13. Birthplace Sedalia Mo (City, town, or county) (State or foreign country)
14. Maiden name Margaret Robinson
15. Birthplace Sedalia Mo (City, town, or county) (State or foreign country)

16. (a) Informant Margaret President
(b) Address 412 N Washington
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6 40 (Month) (Day) (Year)
(c) Place: burial or cremation Sedalia, Mo.
18. (a) Signature of funeral director J. Price Alexander
(b) Address 400 W. Cooper Sedalia Mo.
19. (a) 9-5-40 (Date received local registrar) (b) Mrs. Harry Sneed (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day Oct year 1940 hour 4:30 minute 9 M.
21. I hereby certify that I attended the deceased from Sept 1, 1940, to Oct 14, 1940;
that I last saw h alive on 1, 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho Pneumonia	
Due to Epaemia	
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? 0 0 0 (Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] (M. D. or other) 1
Address Date signed 9-5-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number 11-14-KQ
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 J. Price Alexander, Registered Apprentice No. ____, working under my personal supervision.

Signed J. Price Alexander

Licensed Embalmer No. 3572

P. O. Address Sedalia, 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, fact should be so stated above.

S. No. 2B
M—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. 36008

Registration District No. 668 Primary Registration District No. 3032 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia (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 (Specify whether years, months or days)

In this community

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 Laura Marie Turner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 7

5. Color or age Negro

6. (a) Single, widowed, married, divorced 8

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 7 | Days 11 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4 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.

Immediate cause of death Bronchio Pneumonia

Due to Exposure

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 (M. D. or other)

Address Date signed