

FILED AUG 9 1943 28  
Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

Registrar's No. 607

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 hours  
(Specify whether  
In this community 43 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1127 Hawthorne  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James William Turner

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

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Maud E. Turner 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased June 25, 1881  
(Month) (Day) (Year)

8. AGE: Years 62 Months 1 Days 3 If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business Dry Goods

12. Name Joel Turner

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

14. Maiden name Mrs. Mary Gilliland

15. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maud Turner

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof July 30, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 7-30-43 (b) S. W. Standley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28,  
year 1943 hour 8:30 minute P. M.

21. I hereby certify that I attended the deceased from July 28  
1943 to 7/28/43 1943

that I last saw him alive on 7/28/43 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions not known - died quickly.  
(Include pregnancy within 3 months of death)

Major findings: Of operations 83a

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? \_\_\_\_\_

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

23. Signature Gay D Callaway (M. D. or other) MD  
Address Springfield Mo Date signed 7/29/43

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

MOTHER FATHER

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**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.....

*Lewis G. Schuyler*

Licensed Embalmer No. *3802*

P. O. Address.....

*Springfield, 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.**