

FILED SEP 25 1943  
Registration District No. **2**

Primary Registration District No. **2000**

Registrar's No. **754**

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield

(c) Name of hospital or institution 1030 Perry  
Burger-Cunnelly Nursing Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jack **084**

(c) City or town Salina, Mo. (If outside city or town limits, write "RURAL")

(d) Street No. 209 West Main (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country None **1**

3. (a) PRINT FULL NAME Fattie Lincoln Turner

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11,  
year 1943 hour 6:00 minute P. M.

21. I hereby certify that I attended the deceased from 9/1 '43  
to 9/11 '43,  
that I last saw her alive on 9/11 '43,  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife William Henry Turner

6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased: July 31, 1883  
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage Duration 18 hrs

8. AGE: Years 80 Months 1 Days 10 If less than one day  
hr. min.

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

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

Other conditions Hemiplegia **2**  
(Include pregnancy within 3 months of death)

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

10. Usual occupation House Keeper

11. Industry or business House work

12. Name Nathan Walker Okey

13. Birthplace unk. unknown **9**  
(City, town, or county) (State or foreign country)

14. Maiden name Maria Jane Bell

15. Birthplace unk. unknown **9**  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Wm. H. E. Shaffer

(b) Address Salina, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date of death Sept 11, 1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Salina, Mo.

18. (a) Signature of funeral director Erwin and Blue

(b) Address Salina, Mo.

19. (a) 9-11-43 (Date received local registrar) (b) W. E. Standley (Registrar's signature)

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 W. B. Kemman (M. D. or other) **MD**

Address Springfield Mo Date signed 9/11 '43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>will be</sup> was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Stellard P. Erwin.....

Licensed Embalmer No. 3092.....

P. O. Address Baltimore, Md.....

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.