No. 2
5-42
17-9
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35087

FILED NOV 9 1943

Registration District No. 74

Primary Registration District No. 5644

Registrar's No. 73

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town [illegible]
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 029

(c) City or town Richmond 1
(If outside city or town limits, write "RURAL") 1

(d) Street No. .....
(If rural, give location)

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

If yes, name country 1

3. (a) PRINT FULL NAME ANNA MARY TURNER

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Dorris Turner

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Jan (Month) 21 (Day) 1913 (Year)

8. AGE: Years 30 | Months 8 | Days 26 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name John Eddings
13. Birthplace Carroll Co (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Sallie McQueen
15. Birthplace Saline Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant Dorris Turner
(b) Address Richmond Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Richmond Mo

18. (a) Signature of funeral director Winkler
(b) Address Lexington Mo

19. (a) Oct. 19-43 (Date received local registrar) (b) Mrs. Fred Schwab (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from called in official capacity as coroner 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 Carbon monoxide gas asphyxiation

Due to coroners Jury Verdict
" From Carbon monoxide poisoning

Due to by accident
(gas stove in tourist cabin)

Other conditions none noted
(Include pregnancy within 3 months of death)

Major findings:
Of operations 178c
14
Of autopsy no 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) accident 054

(b) Date of occurrence found on 10-17-43 - 9 pm

(c) Where did injury occur? Lexington (City or town) Lafayette (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at a tourist cabin (Specify type of place)

While at work? No (e) Means of injury 3

23. Signature McMartin Mo Coroner (M. D. or other)

Address Odessa Mo Date signed 10-1

1154

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-8-43

NOV 17 1943

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 Geo. P. McLean

Licensed Embalmer No. 2183

P. O. Address Irvington, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 73

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington Rural
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Anna Mary Turner
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 21 (Day) 18 (Year)

8. AGE: Years 30 Months 8 Days 27 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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) Mrs. Fred Schwab (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17 year 1943 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 — Duration
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

35087