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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 8 1943
Nienssted

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39210

Registration District No. 333

Primary Registration District No. 675 2074

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 40 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

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

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

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sherman Reed Turley

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 14
year 1943 hour 1 minute 45 a.m.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Verbal E. Turley

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased 3 24 1886
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 8, 1943, to Nov 14, 1943
that I last saw him alive on Nov 13, 1943
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>7</u>	<u>20</u>	hr. _____ min.

Immediate cause of death Tumor of Prostate gland

Duration _____

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

Due to _____

Due to _____

10. Usual occupation Farming

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

Major findings: cf Nienssted MD

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Jasper Turley

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

14. Maiden name Elvina Landerm

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

16. (a) Informant Louis E. Turley

(b) Address Sikeston Mo. R.F.D. # 2

17. (a) Burial (b) Date thereof 11/15/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo.

18. (a) Signature of funeral director H.W. Albritton

(b) Address Sikeston Mo.

19. (a) 11/4/43 (b) Louis Landerm
(Date received local registrar) (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 J. Nienssted MD (M. D. or other)

Address Sikeston Mo Date signed 11-18-43

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

1319

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 1243-15

Date Filed 12-6-43

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificaté was embalmed by me, or by.....

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

Signed Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sikeston 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dee

Registration District No. 233

Primary Registration District No. 3074

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(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: _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Sherman Reed Turbe

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m Color w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased mar 24 1888
(Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days _____
If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Tumor of prostate gland malignant

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-39312