

V. S. No. 2  
OM-9-4-41  
Rev. 5-17-39  
I X29484

State File No. ....

FILED MAR 15 1945

Registration District No. 77

Primary Registration District No. 3008

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Mo - 4 DA  
(Specify whether years, months or days)

In this community 6 Mo - 4 DA

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Callaway

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

(d) Street No. 1  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Rachel Turner

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race N

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased July 16 1886  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>7</u>	<u>6</u>	hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Dave Mackaws

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

14. Maiden name unknown

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

16. (a) Informant Records at Hospital

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 2/27/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director V. Atkins

(b) Address 3644 Fenway Ave St. Louis

19. (a) 2-23-1945 (b) Joan Moravitsch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22  
year 1945 hour 1145 minute A M.

21. I hereby certify that I attended the deceased from 8-18 1944 to 2-22 1945  
that I last saw her alive on 2-22 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy

Due to Generalized Arteriosclerosis

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 43

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)

(c) Means of injury \_\_\_\_\_

23. Signature J. B. Stokes (M. D. or other) \_\_\_\_\_

Address Fulton, Mo. Date signed 2/23/45

Duration 1 da

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

14  
1  
2  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed 3-14-45

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

*Louis V. Atkins*

Licensed Embalmer No.

2842

P. O. Address

3644 Finney Av

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.