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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 15 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42277**

Registration District No. **301**

Primary Registration District No. **4442**

Registrar's No. **2072**

1. PLACE OF DEATH:
 (a) County **Ripley**
 (b) City or town **Doniphan**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **William's Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 - hours**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Oregon**
 (c) City or town **Alton**
(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 **Roy Turner**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month **Dec** day **1**
 year **1945** hour **7** minute **15** A.M.
 21. I hereby certify that I attended the deceased from **November 30**, 1945, to **Dec 1**, 1945
 that I last saw him alive on **December 1**, 1945
 and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **S**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Nov. 18, 1925**
(Month) (Day) (Year)

Immediate cause of death **Meningitis**
 Due to **Influenza**
 Duration **24 hours**
 Due to _____
 Duration **6 days**

8. AGE: Years **20** Months **7** Days _____
 If less than one day _____ hr. _____ min.
 9. Birthplace **Posoltes Ark.**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Labourer**

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____
ADDITIONAL INFORMATION REQUESTED
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER, FATHER
 11. Industry or business _____
 12. Name **Ben Turner**
 13. Birthplace **Washington Co Missouri**
(City, town, or county) (State or foreign country)
 14. Maiden name **Thelma C. Clemmons**
 15. Birthplace **Ripley Co Missouri**
(City, town, or county) (State or foreign country)
 16. (a) Informant **Worothy Blankensley**
 (b) Address **Alton, Mo Route # 26**
 17. (a) **Burial** (b) Date thereof **12-4-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Bailey Chapel**
 18. (a) Signature of funeral director **Geo. Cate**
 (b) Address _____
 19. (a) **12-14-45** (b) **C. D. Johnston**
(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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature **J. E. Hulme** (M. D. or other) _____
 Address **Doniphan** Date signed **12/1/45**

674 (Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Licensed Embalmer No.

..... P. O. Address.....

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. Jan
Registrar's No. 2072

Registration District No. 301 Primary Registration District No. 4450

1. PLACE OF DEATH:
(a) County Repley
(b) City or town St. Louis
(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 _____)
In this community _____ years, months or days

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 Ray Turner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 15 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day _____ year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

8. AGE: Years 20 Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Due to meningococcus not found
Due to Influenza
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy ✓

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER {
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 _____ (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)

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. E. Killigrew (M. D. or other) _____
Address St. Louis Mo. Date signed 11/16/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

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