V. S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 29 1947

Registration District No. 340

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19875

Primary Registration District No. 6152

Registrar's No. 14

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Rural Liberty Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3 Miles west of Bernie, Mo.
(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 Missouri (b) County Stoddard

(c) City or town Rural
(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 Carolyn Sue Turner

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

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

4. Sex Female

5. Color or race W

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

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

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

7. Birth date of deceased May (Month) 8 (Day) 1947 (Year)

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

9. Birthplace Stoddard County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name Henry Turner
13. Birthplace Sikeston (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Lucille Houchen
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Henry Turner
(b) Address RFD #1 Bernie

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/47 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetary

18. (a) Signature of funeral director None
(b) Address .....

19. (a) 5/22-47 (Date received local registrar) (b) Lottie Jeffries (Registrar's signature) 257

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16 year 1947 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from May 8, 1947, to May 16, 1947, that I last saw her alive on May 16, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Icterus Neonatorum	8 da
Due to Premature	
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? .....
While at work? ..... (Specify type of place) (e) Means of injury ..... (Auto or other)

23. Signature F O Kelley M.D.
Address Bernie Mo. Date signed 5-17-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 547-759
Date Filed 2-27-47

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 Body Not embalmed, 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.