

No. 2
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-17-39
X-7070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23785
Registrar's No. 15

Registration District No. 97

Primary Registration District No. 5330

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Barreille Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 76 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford
(c) City or town Jonesville Mo
(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 CORNELIA ANGINE TURNBOUGH

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 Louis Ephraim Turnbough 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased Dillard Mo
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days 6
If less than one day hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Jessie Weedon
13. Birthplace Dart, Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Turner
15. Birthplace Dart, Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Turnbough
(b) Address Jonesville Mo

17. (a) _____ (b) Date thereof June 29-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dillard Cemetery

18. (a) Signature of funeral director L. P. Houtson
(b) Address Steckley Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 27
year 1947 hour _____ minute 6 A. M.

21. I hereby certify that I attended the deceased from 4-20 to 6-27
that I last saw him alive on 4-27 and that death occurred on the date and hour stated above.

Immediate cause of death low cerebral hemorrhage
Duration 7 days

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature R. G. Parker (M. D. or other)
Address Steckley Mo Date signed 6-27-47

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

RECEIVED

DISTRICT NO. 5,

District File Number 74740 2

Date Filed 1-23-47

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 Harry Jones

Embalmed

Registered Apprentice No. _____

working under my personal supervision.

Signed Harry Jones

Licensed Embalmer No. 2628

P. O. Address Stebbins MD

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.

Jelly
11-1

Registration District No. 91

Primary Registration District No. 6-230

Registrar's No.

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Coursville
(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)

3. (a) PRINT FULL NAME

Cornelia A. Turnbough

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 Married

6. (b) Name of husband or wife Louie Ephraim Turnbough

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

7. Birth date of deceased July 22 1882

8. AGE:

Years 74 Months 10 Days 10 If less than one day hr. min.

9. Birthplace

Washington Co. Mo.

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)

(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)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Crawford

(c) City or town Davisville
(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 Mo.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1957 hour 12 minute 00 M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

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 _____

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

MOTHER FATHER

TEMPORARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

23785