

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **JACKSON**
(b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **20 DAYS**
In this community **40 YRS.**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **622 HARRISON**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **MARSHALL TURNER**
3. (b) If veteran, name war **DONT KNOW**
3. (c) Social Security No. **DONT KNOW**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **AUGUST** day **26**,
year **1947** hour **5**: minute **25** A.M.
21. I hereby certify that I attended the deceased from **AUGUST**
6, 19 **47** to **AUGUST** **26**, 19 **47**
that I last saw h. **IM** alive on **AUGUST** **26**, 19 **47**;
and that death occurred on the date and hour stated above.

4. Sex **MALE** 21 5. Color or race **NEGRO**
6. (a) Single, widowed, married, divorced **SINGLE**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased **APRIL** **9**, **1882**
(Month) (Day) (Year)

Immediate cause of death **BRONCHO - PNEUMONIA**
Due to **CYSTITIS**
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy
Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day
65 **4** **17**
hr. min.

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

10. Usual occupation **LABORER**

11. Industry or business

MOTHER FATHER { 12. Name **FRANCIS TURNER**
13. Birthplace **TEXAS**
(City, town, or county) (State or foreign country)
14. Maiden name **MARY FRIDIE**
15. Birthplace **TEXAS**
(City, town, or county) (State or foreign country)

16. (a) Informant **SAM DANA (FRIEND)**
(b) Address **815 INDEPENDENCE AVE.**

17. (a) **BURIAL** (b) Date thereof **8 28 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation
18. (a) Signature of funeral director **Highland**
1819 E. 15th St. K.C. Mo.
(b) Address

19. (a) **8-27-47** (b) **Geraldine**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(c) 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) (e) Causes of injury

23. Signature **[Signature]** (M. D. or other) **M.D.**
Address **GENERAL HOSPITAL NO. 2** Date signed **8/26/47**

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.....

John G. Flynn

Licensed Embalmer No. *4283*

P. O. Address *1819 E. 15th, K.C. 2*

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.