

No. 308  
-10-47  
-17-39  
D 3906

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

29998

State File No. \_\_\_\_\_

FILED SEP 13 1948  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3679

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:  
1209 East 31st St. /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. XX (Specify whether  
In this community 55 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1209 East 31st St. 5  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3: (a) PRINT OLIVER CLAUDE TURNER  
FULL NAME

3. (b) If veteran, name war. No 3. (c) Social Security No. None

4. Sex Ma 0 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife. Minnie L. Turner 6. (c) Age of husband or wife if alive. 69 years

7. Birth date of deceased. October 17 1883  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 10 19 hr. min.

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

10. Usual occupation Retired  
Radio Repairman

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

12. Name Thomas J. Turner

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

14. Maiden name Margaret Strips  
(City, town, or county) (State or foreign country)

15. Birthplace Mo. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Minnie L. Turner

(b) Address 1209 E. 31st St.

17. (a) Burial (b) Date thereof 9-9-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director. J.W. Wagner  
(b) Address Kansas City, Mo.

19. (a) 9-8-48 (b) Sheraldine Holman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6th  
year 1948 hour 11: minute 30 P. 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 Generalized Anasarca

Due to Chronic Endocarditis

Other conditions Acute Abdominal Hernia  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Abdominal 1248

Duration  
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 Sheraldine Holman (M.D. or other)  
Address St. Joseph Hospital Date signed 9-7-48

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

MOTHER, FATHER

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**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 Alvin R Haunscheld

- Licensed Embalmer No. 4159

P. O. Address Kansas City

**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.**