

FILED FEB 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3528

6003-54

BIRTH NO. REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 6152 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Stoddard County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Rural Liberty Twp		c. CITY (If outside corporate limits, write RURAL and give OR TOWN Rural Liberty Twp	
c. LENGTH OF STAY (in this place) 16 Days		d. STREET ADDRESS (If rural, give location) 4 miles West of Bernie, Missouri	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4 Miles west of Bernie, Mo.			

3. NAME OF DECEASED (Type or Print) Marilyn Turner			4. DATE OF DEATH (Month) (Day) (Year) 1 18 51		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married U	
8. DATE OF BIRTH 1/2/1951		9. AGE (In years last birthday) 16		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Missouri U		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Henry Turner		13b. MOTHER'S MAIDEN NAME Lucille Houchen		14. NAME OF HUSBAND OR WIFE -----	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE AND NAME ADDRESS Lonnie Rhoades Bernie	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital debility		INTERVAL BETWEEN ONSET AND DEATH 16 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
		DUE TO (c) _____		7730	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 2, 1951, to Jan. 18, 1951, that I last saw the deceased alive on Jan. 17, 1951, and that death occurred at 12:45A m., from the causes and on the date stated above.

23a. SIGNATURE F. O. Kelley, D.O. (Degree or title)		23b. ADDRESS Bernie, Mo		23c. DATE SIGNED 1 25 51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial U		24b. DATE 1/19/51		24c. NAME OF CEMETERY OR CREMATORY Stevens Cemetery	
		24d. LOCATION (City, town, or county) Stoddard County		24e. (State) Missouri	

DATE REC'D BY LOCAL REG. 1-29-51		REGISTRAR'S SIGNATURE Nelson V. Jenkins 409		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS G. H. ... Bernie	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

FEB 6 1951

DISTRICT HEALTH OFFICE No. 6

File No.

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

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *G. J. Tucker*

~~.....~~ *T. J. Tucker*

P. O. Address *Berrie*

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.