

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32244

State File No.

S. No. 300
V. 10. 48

FILED SEP 19 1952

BIRTH NO.		REG. DIST. NO. <u>199</u>		PRIMARY REG. DIST. NO. <u>5730</u>		Registrar's No.			
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Drake Township</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Drake Township</u>		d. STREET ADDRESS (If rural, give location) <u>North West Of Goldsberry Mo</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION		3. NAME OF DECEASED a. (First) <u>Matilda</u> b. (Middle) <u>Florence</u> c. (Last) <u>Turner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9 11 52</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>September 15 1866</u>			
9. AGE (In years last birthday) <u>85</u>		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housekeeper</u>		13a. FATHER'S NAME <u>Thomas L. Nickerson</u>		13b. MOTHER'S MAIDEN NAME <u>Rachel Murry</u>		14. NAME OF HUSBAND OR WIFE <u>Felix Turner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>4221 F</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Robert Dennison</u>		ADDRESS <u>Ethel Mo</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of Femur - Left</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Drake Macon Mo</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>8 - 18 - 52 11:00^A m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from chair</u>					
22. I hereby certify that I attended the deceased from <u>Aug 18</u> , 19 <u>52</u> , to <u>Sept 11</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>Sept 9</u> , 19 <u>52</u> , and that death occurred at <u>12:45 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>B. A. Dineen</u> (Degree or title) <u>D. A.</u>				23b. ADDRESS <u>Bucklin Mo</u>		23c. DATE SIGNED <u>9-12-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 14 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Helton</u>		24d. LOCATION (City, town, or county) (State) <u>Macon Mo</u>			
DATE REC'D BY LOCAL REG. <u>9/17 1952</u>		REGISTRAR'S SIGNATURE <u>Daphne Howerton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. W. & Co.</u>		ADDRESS <u>South Gifford Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

3610
1

RECEIVED
MACON COUNTY HEALTH DEPARTMENT
County File No. 9.52. 144
Date Filed 9.18.52

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. N. M. & Callahan

Licensed Embalmer No. 2052

P. O. Address South Gifford Mo

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.