

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019044  
STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 40

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Charleston</b> <i>06720</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>110 East S. St..</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Bell</b> Last <b>Turner</b>			4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 21, 1874</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - -	11. BIRTHPLACE (City and state or country) <b>Union Co., Ky</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>David Powell</b>		13b. MOTHER'S MAIDEN NAME <b>Sara F. Randolph</b>	14. NAME OF HUSBAND OR WIFE <b>Joseph Turner</b>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. - - - - -	17. INFORMANT <b>Everett L. Patrick, Charleston, Mo.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hours</b>
Conditions, if any, which gave rise to above cause rise to (a), stating the underlying cause last.	DUE TO (b) <b>Carcinoma of bowel</b>	
	DUE TO (c) <b>1539</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Charleston</b>	COUNTY <b>Mississippi</b>	STATE <b>Mo</b>
21. I attended the deceased from <b>May 2/58</b> , to <b>May 3/58</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>May 3/58</b> Death occurred at <b>7:15 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>D. P. Fenton D.O. 2</b>	(Degree or title)	22b. ADDRESS <b>Wyatt Mo</b>	22c. DATE SIGNED <b>5-10-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/5/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>	23d. LOCATION (City, town, or county) (State) <b>Charleston, Mo.</b>
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24. FUNERAL DIRECTOR <b>Mc Mickle Charleston, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>6-6-58</b>	26. REGISTRAR'S SIGNATURE <b>Dorothy B. Haddon</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

RECEIVED

Miss. Co. Health

County File No. \_\_\_\_\_

Date Filed 6-9

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *Elyse M. White*

Licensed Embalmer No. 4642

P. O. Address Charleston

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.