

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35677

State File No.

FILED NOV 15 1955

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 6132 Registrar's No. 339

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>rural Moore typ</u>		c. CITY OR TOWN <u>Rat</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>X</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>Moore typ</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Bessie</u>	b. (Middle) <u>Maude</u>	c. (Last) <u>Turner</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11-6-55</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH <u>Feb 6 1898</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months	IF UNDER 1 HRs. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Reynolds Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S</u>
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13a. FATHER'S NAME <u>George Foster</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Mahan</u>	14. NAME OF HUSBAND OR WIFE <u>Monroe Turner</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Monroe Turner</u>	ADDRESS <u>Rat Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>4 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic carcinoma, generalized</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>carcinoma of breast.</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>170X</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9-27-55 to 11-6-55, 1955, that I last saw the deceased alive on 11-6-55, 1955, and that death occurred at 11:30a., from the causes and on the date stated above.

23a. SIGNATURE <u>W. J. Mitchell M.D.</u>	(Degree or title)	23b. ADDRESS <u>Salem, Mo.</u>	23c. DATE SIGNED <u>11-7-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>11-8-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Turner Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Rat Shannon Co Mo</u>
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DATE REC'D BY LOCAL REG. <u>11-7-55</u>	REGISTRAR'S SIGNATURE <u>W. J. Mitchell M.D.</u>	FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Mitchell M.D.</u>	ADDRESS
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447-67 Model Galleries, Inc. (Licensed Embalmer's Statement on Reverse Side)

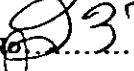
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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.