WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Gasconade

Township Clay

or

Village

or

City (NO. , St.; Ward)

Registration District No. 302 File No. 29272

Primary Registration District No. 6231 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John Turly

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Sep 13 (Month) (Day) 1912 (Year)

AGE yrs. mos. 5 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Nursing
(b) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE (City or town, State or foreign country) Canaan Mo

PARENTS

NAME OF FATHER Otto Turly

BIRTHPLACE OF FATHER (City or town, State or foreign country) ~~Not Kno~~ Indiana

MAIDEN NAME OF MOTHER Bertha Hollandsworth

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Gasconade Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otto Turly

(ADDRESS) C East St. Louis Ill

Filed Sept 19, 1912, C A Bunge MD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sep 18 (Month) (Day) 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 13, 1912, to Sept 18, 1912, that I last saw him alive on Sept 13, 1912, and that death occurred, on the date stated above, at 60 m.

The CAUSE OF DEATH* was as follows:

Premature birth

159

151

(Duration) yrs. mos. 5 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) John L Seba M. D.

Sept 19, 1912 (Address) Bland Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Canaan Mo

DATE OF BURIAL Sept 19, 1912

UNDERTAKER Ed. Hollandsworth

ADDRESS Canaan Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH _____, *1*_____ (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, *191*____ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL _____, 191____

UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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