

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

PLACE OF DEATH
County Randolph,

Township _____
or
Village 5
or
City Moberly, Mo. (NO. 1045 Forest Ave.; 4 Ward)

Registration District No. 735 File No. 30718

Primary Registration District No. 3034 Registered No. 147

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

FULL NAME Mary Elizabeth Turner

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Colored SINGLE MARRIED WIDOWED OR DIVORCED single.
(Write the word)

DATE OF BIRTH Sept. 27, 1913
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. 4 ds. .If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Missouri

NAME OF FATHER Ezra N. Turner

BIRTHPLACE OF FATHER (City or town, State or foreign country) Dalton, Mo.

MAIDEN NAME OF MOTHER Minnie Alexander

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Liberty, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ezra N. Turner
(ADDRESS) Moberly, Mo.

Filed 9/27/13 1913 W. Bloss REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 26, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 25, 1913, to Sept 26, 1913, that I last saw her alive on Sept 26, 1913 and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:
Apnea
119 B
26.
(Duration) _____ yrs. _____ mos. 6 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. 6 ds.
(Signed) J. H. Brown M. D.
Sept 26, 1913 (Address) Moberly, 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 Oakland Cem DATE OF BURIAL 9-27-13

UNDERTAKER Martin & Mahan ADDRESS Moberly, Mo.

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.

W. Bloss

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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.

PLACE OF DEATH

County

Randolph

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Township

Registration District No.

135

File No.

30718

Village

Primary Registration District No.

3034

Registered No.

147

City

Moberly Mo.

(No.)

1045 Forest an

St.:

4

Ward)

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

FULL NAME

Mary Elizabeth Turner

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *Female* COLOR OR RACE *Colored* SINGLE MARRIED WIDOWED OR DIVORCED *Single*
(Write the word)

DATE OF DEATH *Sept 26, 1913*
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from *Sept 25, 1913*, to *Sept 26, 1913*, that I last saw her alive on *on Sept 25, 1913*

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

and that death occurred, on the date stated above, at *5:15* p. m.

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

The CAUSE OF DEATH* was as follows: *Spasms*

BIRTHPLACE (City or town, State or foreign country) _____

(Duration) _____ yrs. _____ mos. *6* ds.

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) _____

Contributory *Intercalitis* (SECONDARY) (Duration) _____ yrs. _____ mos. *6* ds. (Signed) *J. W. Spurr* M. D. *Sept 26, 1913* (Address) *Moberly Mo*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (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 _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted If not at place of death? _____ Former or usual residence _____

REGISTRAR _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
UNDERTAKER _____ ADDRESS _____

Original file, date _____, 19____ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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