

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

29692

1. PLACE OF DEATH

County..... *Russell*

Registration District No. *225*

File No.

Township..... *Jasper*

Primary Registration District No. *2960C*

Registered No.

City..... *Tabitha Turner*

St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *James Turner*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 28 1848*

7. AGE YEARS *76* MONTHS *7* DAYS *5* IF LESS THAN 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER

A. Seely

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Ky*

12. MAIDEN NAME OF MOTHER

Angeline Welch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Ky*

14.

INFORMANT

(Address) *Allen Dulow*

15.

FILED

254th 1924 J. J. Howard

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 1* 19 *24*

17. I HEREBY CERTIFY That I attended deceased from *Sept*

18 to *Oct* 19 *24*

that I last saw him alive on *Oct 1* 19 *24* and that

death occurred, on the date stated above, at *11 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS

Chronic nephritis

CONTRIBUTORY

(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *H. J. ...* N. D. *Oct 1 1924*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Salem Cemetery

Oct 3 1924

20. UNDERTAKER

J. J. ...

ADDRESS

Centerville 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.

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1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City..... (No.)..... St..... Ward.....

2. FULL NAME

(a) Residence. No..... Ward.....
(Usual place of abode).....
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND or (or) WIFE or

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

10. NAME OF FATHER.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS

14. INFORMANT.....
(Address)

15. FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., and that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY.....
(SECONDARY)..... (duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs. mos. da.
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VICARIOUS CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL.....

DATE OF BURIAL.....

20. UNDERTAKER.....

ADDRESS.....