

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

Do not use this space.

13823

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis, Mo.** (No. **City Hosp. No. 2**)

File No.....

Registered No. **4590**

St. Ward

**2. FULL NAME**

**Baby Turner**

(a) Residence No. **2837 Lawton** St. **21** 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. **8** da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

**male.**

**4. COLOR OR RACE**

**negro**

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

**single**

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** **April 11, 1927**

**7. AGE**

YEARS

MONTHS

DAYS

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

**8**

**8. OCCUPATION OF DECEASED**

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

**nil**

(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)

**St. Louis**

**10. NAME OF FATHER**

**Jesse Turner**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**Mo.**

**12. MAIDEN NAME OF MOTHER**

**Cecile Harris**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**Mo.**

**14.**

INFORMANT

(Address)

**Anna F. Woodard  
City Hospital # 2**

**15.**

FILED

19

**Mar 6 Dan Coffey**

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** **April 19 19 27**

**17. I HEREBY CERTIFY, That I attended deceased from April 11, 19 27, to April 19, 19 27, that I last saw him alive on April 19, 19 27, and that death occurred, on the date stated above, at**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Premature Infant**

**CONTRIBUTORY (SECONDARY)**

**159 16/A**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

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

**20. WAS THERE AN AUTOPSY?**

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) **J. W. Gray**, M. D.

, 19 (Address) **City Hosp. No. 2**

\*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.

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

**DATE OF BURIAL**

**POTTER'S FIELD.**

**5-18-19 27**

**20. UNDERTAKER**

**ADDRESS**

**R. Aston 2945 Lawton**

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.

