

OCT 4 1927

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

Do not use this space.

26354

1. PLACE OF DEATH

County NorthRegistration District No. 984Township SherridanPrimary Registration District No. H046City Sherridan (No.)

File No.

Registered No.

St. Word)

2. FULL NAME

(a) Residence No. Gas Benson Turner St. Word.

(Usual place of abode)

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

MaleWhiteMarried

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

Lizzie Turner6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 6 - 1857

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

7017

8. OCCUPATION OF DECEASED

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

Retired

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

4

(c) Name of employer

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

10. NAME OF FATHER

James Turner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Sarah Carter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

Gas Benson Turner
Sherridan Ill.

15.

FILED

Aug 17, 1927J.W. Nigh

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 13 1927

17.

I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1927, to Aug. 13, 1927, that I last saw him alive on Aug. 13, 1927, and that death occurred, on the date stated above, at 8:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia of (Left) of brain820

(duration) yrs. mos. ds.

CONTRIBUTORY Hemiplegia of brain (Right)
(SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? NO DATE OFWAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Francis G. Johnson M. D., 19 (Address) Sherridan Missouri

*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

Sherridan Cemetery8-16-27

20. UNDERTAKER

ADDRESS

Orv. Burkh. Frank City Mo

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.

