

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

Do not use this space.

1649

1. PLACE OF DEATH

County Laclede
Towship Union
City..... (No.....).....

Registration District No. 448
Primary Registration District No. 5608

File No.....
Registered No. 1
St..... Ward.....

2. FULL NAME Georgie Jean Turner

(a) Residence. No..... St..... Ward.....
(Usual place of abode)
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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 8 - 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
1 1 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(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) Laclede Co Mo

10. NAME OF FATHER Edwood Turner

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

12. MAIDEN NAME OF MOTHER Edie Sturdivant

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

14. INFORMANT Edwood Turner (Address) Phelpsburg Mo

15. FILED Jan 10 1928 H. B. Blanton REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 4 19 28

17. I HEREBY CERTIFY, That I attended deceased from 11-18 1927, to 1-2-30 1927, that I last saw h. live on 1-2-27, 1927, and that death occurred, on the date stated above, at 8:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Congenital Heart Disease
1590 aortic stenosis?

CONTRIBUTORY (SECONDARY) 1590 (duration) yrs. 1 mos. 15 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) E. A. Solomon M.D.

, 19 (Address) Lebanon Mo

*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

Lansing Hill Cem 19 28

20. UNDERTAKER ADDRESS

Hobman & Stewart Lebanon 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.

1919

1945

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Laclede Registration District No. 448 File No. _____
 Township Union Primary Registration District No. 2-16-08 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Georgie Jean Turner

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>S</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

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

14.

INFORMANT _____
 (Address)

15.

FILED Jan 10, 26 M. B. Clinton
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ also 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. _____ ds.

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) _____, M. D.
 _____, 19____ (Address)

*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 _____

20. UNDERTAKER

Helmon & Stewart Lebanon

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

SUPPLEMENTARY

5-1649