

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

Do not use this space.

28143

1. PLACE OF DEATH

County Jasper Registration District No. 417
Township West City Primary Registration District No. 3021
City West City (No. _____) St. _____ Ward _____

File No. _____
Registered No. 113
St. _____ Ward _____

2. FULL NAME

James Thomas Turner
(a) Residence No. James Thomas Turner Hospital 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30 1914

| | | | | |
|--------|-------|--------|------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
| | 15 | 7 | 9 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 207 School 103
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER James Turner

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

12. MAIDEN NAME OF MOTHER Lula Webb

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

14. INFORMANT Mrs. Lula Curtis
(Address) 118 S. Galena St. Joplin

15. FILED 8/21 1929 R. M. Schmidt REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1929

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ d. to _____ 19____
that I last saw him live on Aug 20 _____ 19____ and that death occurred, on the date stated above, at _____ m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage and shock -
Result of being
struck by train
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Sam Simmons M. D.
9/20 1929 (Address) Normal, Jasper Co. 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 Fairview Cem DATE OF BURIAL 9/22 1929

20. UNDERTAKER Webb City ADDRESS Webb City

11-11-11 11:11:11

11-11-11 11:11:11

11-11-11 11:11:11

11-11-11 11:11:11

11-11-11 11:11:11

11-11-11 11:11:11

11-11-11 11:11:11

11-11-11 11:11:11

11-11-11 11:11:11

**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 Gasper Registration District No. 217 File No. _____
 Township _____ Primary Registration District No. 3021 Registered No. 113
 City Webb City (No. _____) St. _____ Ward _____

2. FULL NAME

Herman 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>M</u> | 4. COLOR OR RACE <u>W</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>S</u> |
| 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. | |
| 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 | | |

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1899

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Heart failure & shock
result of being struck
by train (see Neal note - walking
at R. track. (duration) _____ yrs. mos. ds.

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) _____ 235 _____, M. D.
 _____, 19____ (Address)

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 9/30 29 R. M. Stormon REGISTRAR

*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 | ADDRESS |

SUPPLEMENTARY

REGISTERED BY LAW
 NO. 604
 IF FOR-GERY IFICATES UNTIL THEY ARE COMPLETE.

S-28143