

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

Do not use this space.

28334

1. PLACE OF DEATH

County Macdon

Registration District No. 531

Township White

Primary Registration District No. 5709

City Edwardsburg (Name)

File No. _____

Registered No. _____

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

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

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

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

Jan 13 1849

7. AGE

YEARS

MONTHS

DAYS

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

80

7

6

8. OCCUPATION OF DECEASED

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

Farmer

(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)

Ky

10. NAME OF FATHER

Pelix Turner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ky

12. MAIDEN NAME OF MOTHER

Lusinda Turner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ky

14.

INFORMANT (Address)

Reuben Turner
Suffolk Mo

15.

FILED

9-10-1929

J. G. Shacklett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Aug 19 1929

17.

I HEREBY CERTIFY, That I attended deceased from

Aug 10

1929 to Aug 19 1929 that I last saw him alive on Aug 18 1929, and that death occurred, on the date stated above, at 12 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Nephritis chronic

131 / 54 / 110
134 / 54 / 110

CONTRIBUTORY (SECONDARY)

Epilepsy

(duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

at home

19. DID AN OPERATION PRECEDE DEATH?

No

WAS THERE AN AUTOPSY?

No

WHAT TEST CONFIRMED DIAGNOSIS?

Chemical

(Signed)

James W. St. John M. D.
, 19 (Address) Galesburg 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

Walter

Aug 21 1929

20. UNDERTAKER

ADDRESS

W. H. McCallum
Smith & Hays

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.

THIS IS A PERMANENT RECORD

