

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

Do not use this space.

32377

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1002**
 City **St. Louis Mo.** (No. **City Hosp 2**)

File No.....
 Registered No. **9474**
 St. Ward)

2. FULL NAME **Joseph M. TURNER**

(a) Residence No. **4633 Margaretta** 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 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		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 11 - 1889		
7. AGE YEARS 40	MONTHS	DAYS 11
If LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Kansas City Mo**
 (STATE OR COUNTRY)

10. NAME OF FATHER **Joseph A Turner**

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

12. MAIDEN NAME OF MOTHER **Mary Haddigan**

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

14. INFORMANT **Joseph A Turner**
 (Address) **4633 Margaretta**

15. FILED **SEP 23 1929** **Map C. Tanker**
 19..... REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 22 1929**

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 **3 AM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Muriatic Acid Poisoning self-administered at residence while suffering temporary mental aberration (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) **Suicide** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? DATE OF.....
 WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) **J. W. Kerney M.D.**
 Address) **Dep. Cora**

*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 **Galvray Cemetery** DATE OF BURIAL **9/24 29**

20. UNDERTAKER **Brook Carroll** ADDRESS **4600 Natl Bldg**

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.

321
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