

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

Do not use this space.

32729

1. PLACE OF DEATH

County... *Shelby Co.*
Township... *Tiger Fork*
City... (No.) (Ward)

Registration District No. *1024*
Primary Registration District No. *6088*

File No. *9*
Registered No.
St. Ward

2. FULL NAME

Maude W. 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *E. T. Turner*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 5th 1863*

| | | | | |
|-----------|----------|-----------|------|--|
| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
| <i>66</i> | <i>4</i> | <i>23</i> | | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House Keeper*
(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) *Boon County, Mo.*

10. NAME OF FATHER

L. Riveony

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Boon County, Mo.*

12. MAIDEN NAME OF MOTHER

Morthy Hall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Boon Co.*

14.

INFORMANT *E. T. Turner*
(Address) *Bethel Mo*

15.

FILED *Nov 19 1929* *C. C. Cabert*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 28* 19 *29*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 28*, 19*29*, to *Sept 28*, 19*29*, that I last saw him alive on *Sept 28*, 19*29*, and that death occurred, on the date stated above, at *a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Arteriosclerosis
935*

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY..... *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Cholera*
(Signed) *L. L. Smith*, M. D.

9/29, 1929 (Address) *Bethel 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

Bethel Chapel

DATE OF BURIAL

Sept 29 1929

20. UNDERTAKER

Brothus + Hawkins

ADDRESS

Bethel Mo

WRITE FULLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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