

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

Do not use this space.

APR 23 1930

7841

1. PLACE OF DEATH

County Richman

Registration District No. 1001

File No. _____

Township _____

Primary Registration District No. _____

Registered No. 388

City St. Joseph Mo (No. State Hospital for Insane No. 31 Ward)

2. FULL NAME

Oliver L. Turner

(a) Residence, No. _____ St., _____ Ward. Kansas City, Mo.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 9 mos. 12 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)

Married

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

Mary Turner

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

year 1858

7. AGE

YEARS

MONTHS

DAYS

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

72

unk

unk

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Iowa

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Unknown

INFORMANT

(Address)

State Hospital for Insane No. 31

St. Joseph, Mo. Records

FILED

MAR 26 1930

John L. [Signature]

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 27 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 7, 1930, to Mar 27, 1930, that I last saw him alive on Mar 26, 1930, and that death occurred, on the date stated above, at 8:10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Endocarditis

92A

90A

CONTRIBUTORY (SECONDARY)

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) B. E. Miles, M. D.

Mar 27 1930 (Address) St. Joseph, Mo.

*State the DISEASE CAUSING DEATH, 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

Kansas City, Mo

Mar 29 1930

20. UNDERTAKER

ADDRESS

Heaton-Betts & Bowman

319 S. 10th

Funeral Home

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.

