MAY 28 1930

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

Do not use this space.
15002

File No. 1203
Registered No. 38

1. PLACE OF DEATH
County Saline
Township Gambridge
City Slater (No. ..... St. ..... Ward)
Registration District No. 799
Primary Registration District No. 4479

2. FULL NAME Mrs. Emma Jane 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: 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 James Turner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-6-1872

7. AGE: Years 57 | Months 9 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(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) Saline Co. Mo.

PARENTS
10. NAME OF FATHER John Hardin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Va
12. MAIDEN NAME OF MOTHER Bernie Workman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Va

14. INFORMANT W. P. Hardin
(Address) Slater Mo.

15. FILED 4 19, 1930 W. M. Tuttle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 17 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1930 to April 17, 1930 that I last saw her alive on April 17, 1930 and that death occurred, on the date stated above, at 11 - p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis Chronic
93C.
(duration) yrs. 6 mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED? At Home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) N. E. Lockwood, M. D.
, 19 (Address) Slater 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: Rehoboth Cemetery | DATE OF BURIAL: 4-30-1930
20. UNDERTAKER: Hill Brothers | ADDRESS: Slater

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

1950 4 17
1872 7 6
9 11