

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

Do not use this space.

20343

**1. PLACE OF DEATH**

County Ralls  
Township Lawton  
City St. Louis

Registration District No. 547 724  
Primary Registration District No. 3029 5958  
(No. Ralls County)

File No. 145 17  
Registered No. 145 17  
St. St. Louis Ward 17

**2. FULL NAME**

(a) Residence No. 4130 N. 4th St. St. Louis Ward 17

(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) Widowed

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Madison Turner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 14, 1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
80 10 24

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Troy Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Wm R. Dodge

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

12. MAIDEN NAME OF MOTHER Mary E. Lambert

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

14. INFORMANT John H. Hardmeyer  
(Address) Ralls County

15. James E. Cousins REGISTRAR  
T. J. Duncanson

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/2/1930

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930 to June 2, 1930  
that I last saw him alive on May 31, 1930, and that death occurred, on the date stated above, at 7:30 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Fractured Hip 1864  
1323  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Anemia  
(duration) yrs. mos. ds. 2 mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH Hamlet S.D.

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

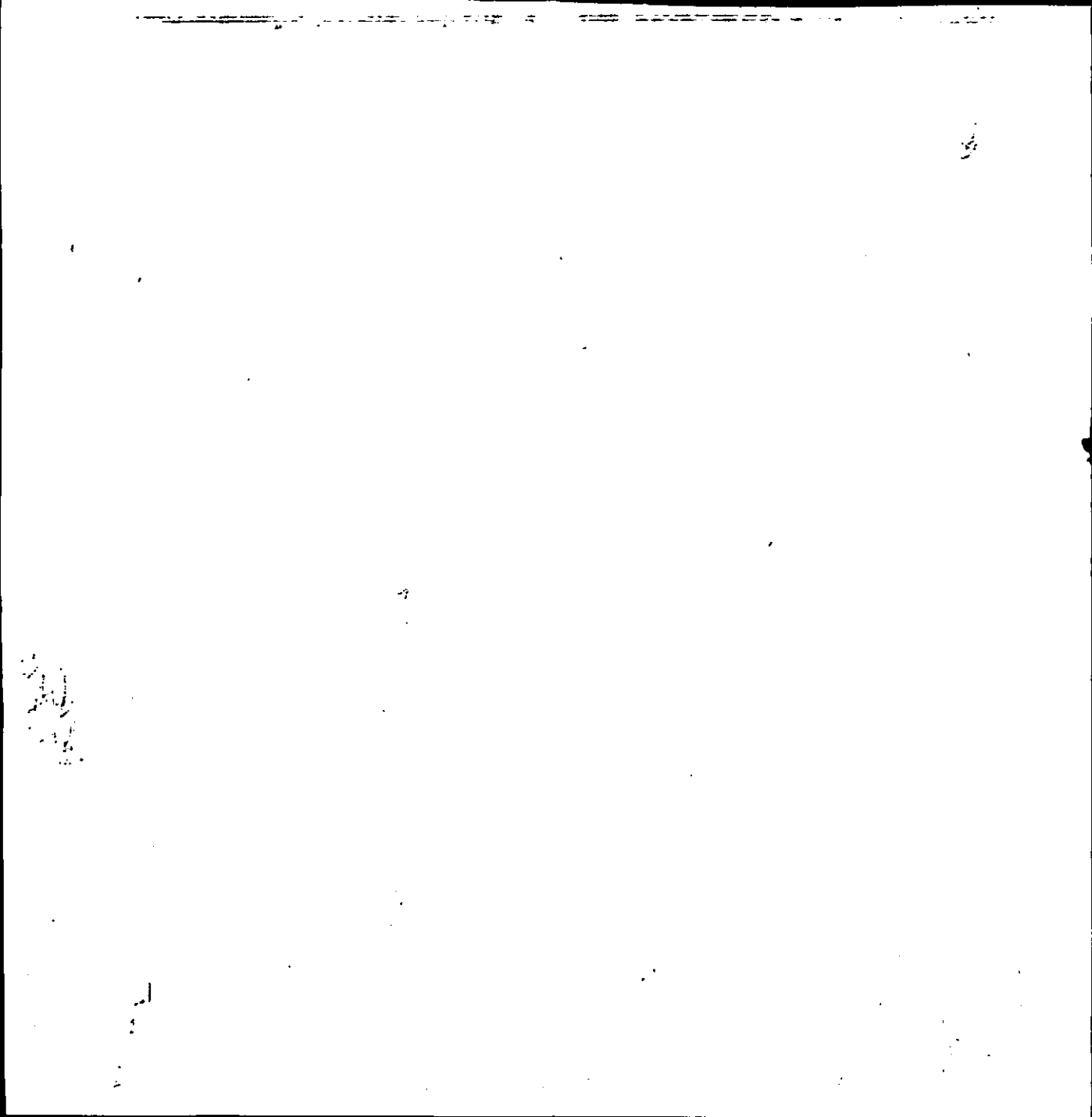
WHAT TEST CONFIRMED DIAGNOSIS General suppurative  
(Signed) A. L. Shurt M. D.

6-10, 1930 (Address) Hamlet S.D.

\*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 St. Olivet Cemetery DATE OF BURIAL 6/4/1930

20. UNDERTAKER James O'Donnell ADDRESS Hamlet S.D.



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ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County St. Louis Registration District No. 726 File No. 20343  
Township Saverton Primary Registration District No. 5958 Registered No. 17  
City (No. ....) St. .... Ward)

**2. FULL NAME** Mary E. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

INFORMANT (Address)

FILED ..... 19 .....

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2 19 30

17. I HEREBY CERTIFY, That I attended deceased from ..... to .....  
that I last saw h. .... alive on ..... 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Fractured hip  
fall in home  
(duration) yrs. mos. ds.  
CONTRIBUTORY urine  
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? h

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

, 19 (Address)

\*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

20. UNDERTAKER

ADDRESS

19

S-20343