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.

DEC 29 [illegible]

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

Do not use this space.

36635

1. PLACE OF DEATH

County Laclede — Registration District No. 448 — File No.

Township Union — Primary Registration District No. 5608 — Registered No.

City Phillipsburg (No. ..... St. ..... Ward)

2. FULL NAME Elbert Lafayette Turner

(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Husband of Iva Turner

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
53			12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer & Stockman

(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): Laclede Co. Mo.

PARENTS

10. NAME OF FATHER: Sanford Turner

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

12. MAIDEN NAME OF MOTHER: Caroline Stone

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Galena Mo. Stone Co. Mo.

14. INFORMANT: Mrs. Iva Turner
(Address) Phillipsburg Mo.

15. FILED Dec 24 1930 Jennie H. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 13, 1930

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to Nov. 13, 1930 that I last saw him alive on Nov. 13, 1930, and that death occurred, on the date stated above, at 11-30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

High blood pressure

about 12 (duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage First Hemorrhage about 2 years Last (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs & Symp

(Signed) O. Daylor, M. D.

, 19 (Address) Phillipsburg, 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	DATE OF BURIAL
Bear Thicket	11-14 1930

20. UNDERTAKER	ADDRESS
W. E. Holman	Conway, Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Laclede Registration District No. 448 File No.
Township Union Primary Registration District No. 5608 Registered No.
City (No. , St. Ward)

2. FULL NAME Elbert Lafayette 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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 1 1877

7. AGE: 53 YEARS | MONTHS: 0 | DAYS: 12 | 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) Laclede

PARENTS
10. NAME OF FATHER Sanford
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Caroline Stone
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Talena Mo

14. INFORMANT (Address)

15. FILED Dec 20 1930 Jennie H Blinton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 13 1930

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 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY (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?
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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

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 imp

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-36635