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

Do not use this space.

(A) 38382-A

File No. 31

Registered No.

Registration District No. 903

Primary Registration District No. 4543

1. PLACE OF DEATH
County Worth
Township Grant
City Grant City (No. , St. Ward)

2. FULL NAME Frank Downing Tanner
(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 5 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

JAN 23

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| M | W | Married |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30 1870

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..hrs. or ..min. |
|---|---|---|---|---|
| | 59 | 9 | 22 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ways Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lexington
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Edward Tanner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) England
12. MAIDEN NAME OF MOTHER Fabrie Dick
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Wisconsin

14. INFORMANT Mrs Clara Tanner
(Address) Grant City, Mo.

15. FILED 11/24/1930 John Anderson REGISTRAR

## 2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22 1930

17. I HEREBY CERTIFY, That I attended deceased from June -, 19[illegible], to Nov 22, 1930, that I last saw h[illegible] alive on Nov 22, 1930, and that death occurred, on the date stated above, at 5:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of rectum
460

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 45

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH V
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Sept 1929
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Surgical findings
(Signed) C F Nash, M. D.
, 19 (Address) Grant City 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 |
|---|---|
| Grant City Cemetery | 11/24/1930 |
| 20. UNDERTAKER | ADDRESS |
| Funk & Dunfee | Grant City |

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. [illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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 Worth Registration District No. 903 File No.
Township Primary Registration District No. 4-5-43- Registered No. 31
City Grant City (No. St. Ward)

2. FULL NAME Orrin K Downing 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| M | W | M |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30-1870

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 60 | 9 | 22 | |

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)

PARENTS

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)

14. INFORMANT
(Address)

15. FILED 2-10 1931 John Andrews REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22 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 given EXACTLY. OCCUPATIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

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