

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

Do not use this space.

8369

File No. 2840
Registered No. 2840
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City St. Louis mo. (No. City 70 map # 2)

2. FULL NAME

Elsie Turner
(a) Residence. No. 1314 N. 15th St. St. 25 Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>6-5-1913</u>		
7. AGE	YEARS	MONTHS
	<u>17</u>	<u>8</u>
		DAYS
		<u>22</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Widow</u>		
(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) Ark

10. NAME OF FATHER Flar Turner

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

12. MAIDEN NAME OF MOTHER Agnes Frank

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

14. INFORMANT A. G. Trade Creath
(Address) City 70 map # 2

15. FILED _____, 19____, _____, _____
REGISTRAR W. C. Stanley

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-27 1931
17. I HEREBY CERTIFY, That I attended deceased from 1/19 1931 to 2/27 1931 that I last saw him alive on 2/27 1931 and that death occurred, on the date stated above, at 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
(duration) 3 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED Home (i)
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical - tub
(Signed) Henry E. Hampton, M. D.
3/2 1931 (Address) City Hospital #2

*State the DISEASE CAUSING DEATH, or if 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 E. St. Louis Ill
DATE OF BURIAL 3-5 1931
ADDRESS 357 Soledade
20. UNDERTAKER A. M. Green

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.

WHILE ALIVE, WITH UNFADING INK—THIS IS A PERMANENT RECORD

