

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

Do not use this space.

8390-1

83-90-1

MAY 27 1931

1. PLACE OF DEATH
 County Washington Registration District No. 226 File No. _____
 Township _____ Primary Registration District No. 45107 Registered No. _____
 City Irondale (No. _____) St. _____ Ward _____

2. FULL NAME William 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) WIDOWER

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/12/1856

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	74	4	21	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Care taker 248
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Edwin Turner

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

12. MAIDEN NAME OF MOTHER Dont know

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

14. INFORMANT Edwin H. Turner
 (Address) Springfield, Mo

15. FILED 5/8 31 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/3 1931

17. I HEREBY CERTIFY, That I attended deceased from 2/20, 1931 to 2/20, 1931 that I last saw him alive on 2/20, 1931 and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy

82A
 (duration) yrs. mos. ds. 1

CONTRIBUTORY (SECONDARY) [Signature]
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH (1)

19. DID AN OPERATION PRECEDE DEATH? DATE OF 8

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. P. Yeargan, M. D.
 , 19 (Address) Irondale, M

*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 Quincy, Ill DATE OF BURIAL 2/25 1931

20. UNDERTAKER C. J. Hill ADDRESS _____

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is essential. Cause of DEATH in plain terms, so that it may be properly classified.

5-8590-1 ..