WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

3805

1. PLACE OF DEATH

County ..... Registration District No. 781 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 763

City St Louis (No. 111 S. Ewing Ave. St. ..... Ward)

2. FULL NAME Peter Turner

(a) Residence, No. 111 S. Ewing St., 21 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: Male
4. COLOR OR RACE: Col.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower

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

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

7. AGE: Years abt. 58 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Building
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): West Point Mississippi

FATHER
13. NAME: Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): West Point Mississippi

MOTHER
15. MAIDEN NAME: Lena Reiss
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Clifton Turner 111 S. Ewing Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park Cem DATE 1/23 1933

19. UNDERTAKER (ADDRESS): Peoples Und Co. 3100 Franklin

20. FILED JAN 21 1933 Max C. Pandey Registrar.

MEDICAL CERTIFICATE OF DEATH

No Physician in Attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 18, 1933

22. I HEREBY CERTIFY That I attended deceased from Found Dead, 19..., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 330a m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis 930

Date of onset

Other contributory causes of importance: 930

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) [signature], M. D.

(Address) Deputy Coroner

1/19/33