

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

Do not use this space.

4081

1. PLACE OF DEATH

County..... Registration District No. *4802*
 Township..... City Registration District No. *St. Louis*
 City *St. Louis* (No. *St. John's Hospital*) St. Ward)

File No.
 Registered No. *1049*

2. FULL NAME

(a) Residence, No. *4605 Lindell Blvd. 12* Ward.

(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) *Married.*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Beatrice Clark*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 2nd 1870*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 5 27

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Vice Pres*
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Scullin Mfg Co*
 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) *St. Louis*

FATHER
 13. NAME *John W. Turner*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New York*

MOTHER
 15. MAIDEN NAME *Blanche Douland*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*

17. INFORMANT *Edna Randolph*
 (ADDRESS) *N. M. ...*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE *Calvary* DATE *Jan 31st 1933*

19. UNDERTAKER *Wagoner Lyle Co.*
 (ADDRESS) *13621 Olive St.*

20. FILED *14N 30 1933*
Max C. Starnes Registrar.

2. MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 29, 1933*

I HEREBY CERTIFY, that I attended deceased from *Jan 28*, 19*33*, to *Jan 29*, 19*33*
 I last saw him alive on *Jan 28*, 19*33*. Death is said to have occurred on the date stated above, at *4a* m.

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

Coronary Thrombosis
930

Date of onset *Jan 28*

Other contributory causes of importance:

Myocarditis Chr.

Name of operation *none* Date of
 What test confirmed diagnosis? *clinical* 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? *no*
 If so, specify
 (Signed) *Conroy*, M. D.

(Address) *124 3rd mobile*

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.

WHITE PAPER WITH UNFADING INK—THIS IS A PERMANENT RECORD

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