

APR 24 1933

*K. B. Big*

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

Do not use this space.

12078  
216-23

1. PLACE OF DEATH

10 (1) County *East*  
Township *Richland*  
City *Bixston* (No. ....)

Registration District No. *871*  
Primary Registration District No. *6670*

File No. ....  
Registered No. ....  
St. .... Ward

2. FULL NAME

*Louise Turley*

(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 *Man* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Child*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 23 1922*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*11 11 30*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Child*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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) *Bixston Mo*

13. NAME *Sherman Turley*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Quilman Co Mo*

15. MAIDEN NAME *Verba Lande*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Iola Mo*

17. INFORMANT *Sherman Turley* (ADDRESS) *Bixston Mo*

18. BURIAL, CREMATION OR REMOVAL PLACE *Bixston* DATE *Mar 24 1933*

19. UNDERTAKER (ADDRESS) *W. G. W. Co*

20. FILED *4/10/33* *Walter Dean* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 22 1933*

22. I HEREBY CERTIFY, That I attended deceased from *March 21* 19*33* to *March 22* 19*33*

I last saw ~~him~~ alive on *March 22* 19*33*. Death is said to have occurred on the date stated above, at *11:00* m.

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

*Peritonitis*

*12:15*  
*12:15*

Other contributory causes of importance:

Name of operation *appendectomy* Date of *3-21-33*

What test confirmed diagnosis? *✓* Was there an autopsy? *no*

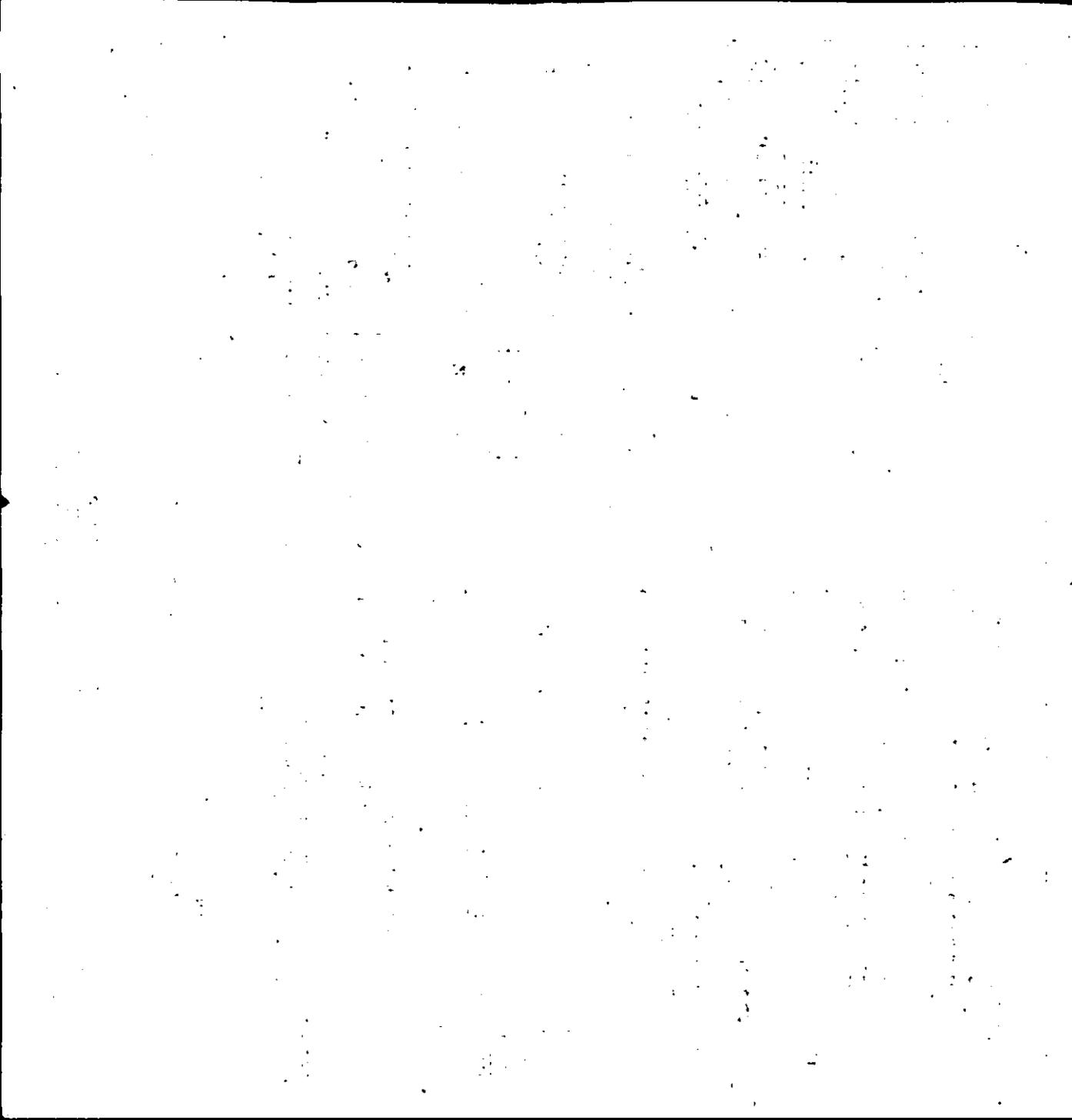
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19...

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) *Cliff Prunell*, M. D. (Address) *Bixston Mo*



**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 Scott  
Township Richland  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 821  
Primary Registration District No. 6070

File No. 26  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Lonnie Turley

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 2 -  
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 22, 19 93

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

Other contributory causes of importance: 121

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

Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation appendectomy Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_.

15. MAIDEN NAME

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. UNDERTAKER (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

20. FILED 4/10/33 19\_\_\_\_ W. H. Edens  
Registrar

(Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

**SUPPLEMENTARY**

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

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