

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

Do not use this space.

**JUN 5 1935**

15325

**1. PLACE OF DEATH**

County Sullivan  
Township Green  
City Green Castle (No. \_\_\_\_\_)

Registration District No. 849  
Primary Registration District No. 4574

File No. \_\_\_\_\_  
Registered No. 17  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Malinda Jane 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-9-1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
82      7      7

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

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) Ill.

13. NAME Mary Sullivan

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

15. MAIDEN NAME Wm. Smith

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

17. INFORMANT Mrs. Edgar Purvis  
(ADDRESS) Green Castle, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Green Castle DATE 4-19 1935

19. UNDERTAKER Olen E. Keast  
(ADDRESS) Green Castle, Mo.

20. FILED May 16 1935 Virginia Libron  
Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 16 1935

I HEREBY CERTIFY, That I attended deceased from Feb 18 1935 to April 16 1935

I last saw her alive on April 15 1935 Death is said to have occurred on the day stated above, at \_\_\_\_\_ m.

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

Shock from fall and senile debility

Other contributory causes of importance:

Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? at home (Specify city or town, county, and State)

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

Manner of injury fall from house

Nature of injury bruises

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_ (Signed) W. J. Taylor M. D.

(Address) Green Castle, Mo.

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.

Fall Mother 2002

