Dr Turner

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

Do not use this space.

30065

OCT 25 1935

1. PLACE OF DEATH
County Macon — Registration District No. 533 — File No.
Township Hudson — Primary Registration District No. 5713 — Registered No. 215
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Villa Decker

(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 W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ~~9~~ — ~~9~~

7. AGE — YEARS ✓ — 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. Retired
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) County Infirmery Cake

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Records

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) James Elliott County Infirmery

18. BURIAL, CREMATION, OR REMOVAL
PLACE Woodlawn Cem. DATE 10-1-1935

19. UNDERTAKER (ADDRESS) Stephens & Goodding Macon, Mo.

20. FILED 10/12 1935 Leota Newton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-29th, 1935

22. I HEREBY CERTIFY, That I attended deceased from May 1931, to Sept 29, 1935
I last saw her alive on 9-29, 1935 Death is said to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Apoplexy	Sept 1935
[illegible]	
Other contributory causes of importance: Arterio Sclerosis	10 ?

Name of operation ..... 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? .....
(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) T F Turner, M. D.
(Address) .....

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.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH
County: Macon — Registration District No.: 533 — File No.:
Township: Hudson — Primary Registration District No.: 5713 — Registered No.: 316
City: (No. , St. Ward)

2. FULL NAME: Villa Decker

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*)

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

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

7. AGE — YEARS: (Between 75 and 80) — 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.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. UNDERTAKER
(ADDRESS)

20. FILED 10/12 1935 Leota Newton
Registrar.

MEDICAL CERTIFICATE OF DEATH

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

Other contributory causes of importance:

Name of operation 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?
(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) J. I. Turner, M. D.
(Address)

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