

JAN 23 1935

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

✓ Do not use this space.

39646

1. PLACE OF DEATH

Country Kansas Registration District No. 399  
Township West Primary Registration District No. 1002  
City Kansas City (No. St. Joseph Hospital) St. 1000 Ward 1000

File No. \_\_\_\_\_  
Registered No. 47000  
St. 1000 Ward 1000

2. FULL NAME Donald P. Turner

(a) Residence, No. Turner, Kans. 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

3. SEX <u>Male</u>	4. COLOR, OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Emmie Turner</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 14, 1900</u>		
7. AGE	YEARS <u>35</u>	MONTHS <u>4</u>
	DAYS <u>4</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Investigator</u>	
	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) <u>Kansas City, Kansas</u>		
FATHER	13. NAME <u>Robert Turner</u>	
	14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) <u>Ill.</u>	
MOTHER	15. MAIDEN NAME <u>Lora Bradley</u>	
	16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) <u>Kansas City, Kans.</u>	
17. INFORMANT (ADDRESS) <u>Mr Robert Turner</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Maple Hill 15-17-35</u>		
19. UNDERTAKER (ADDRESS) <u>H. Zimmerman &amp; Sons, 5735 Prospect, K.C. Mo.</u>		
20. FILED <u>Dec 17, 1935 M.M. Covine</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

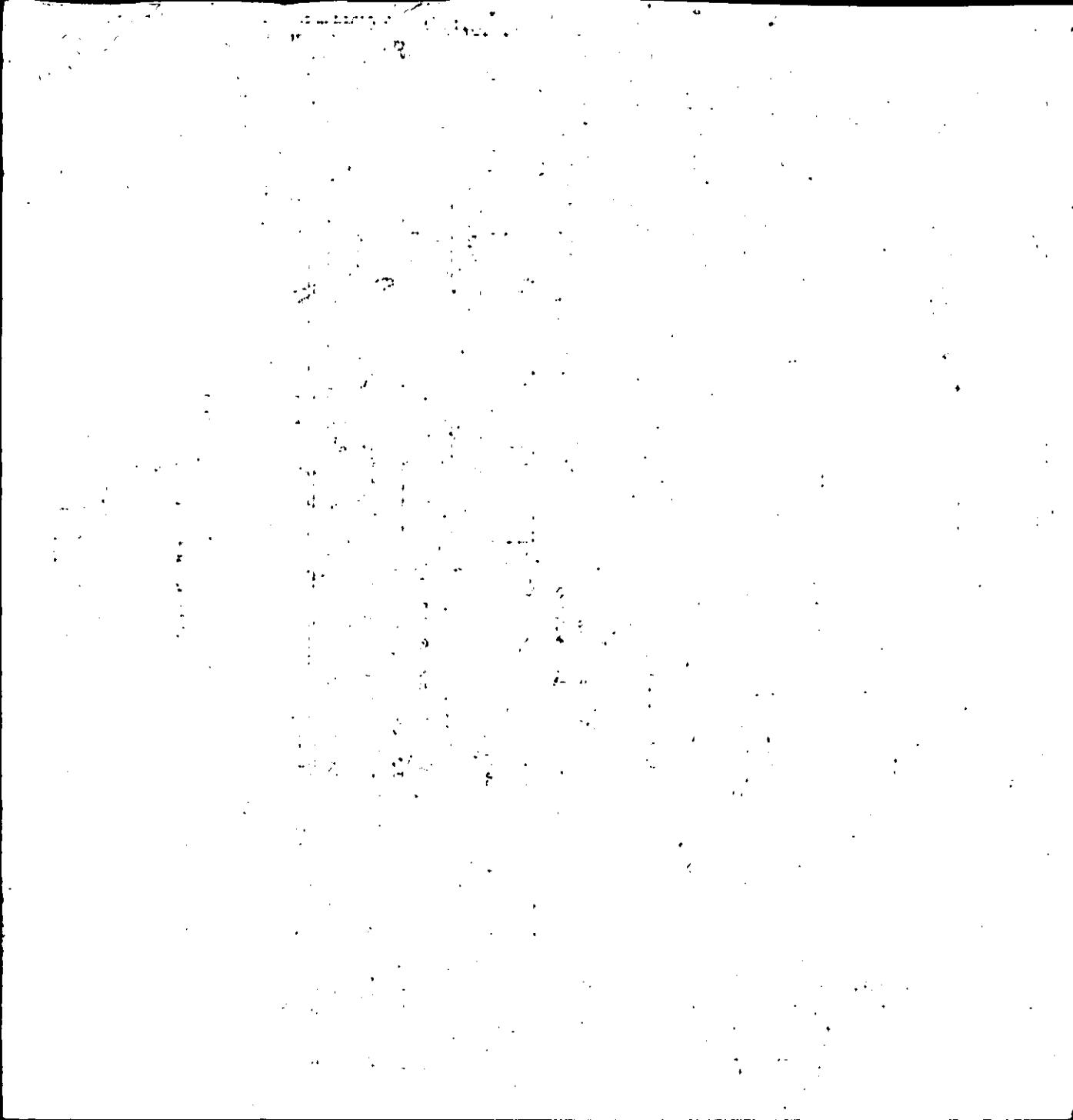
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/15/35

22. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner, 19\_\_\_\_, 19\_\_\_\_. I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m. The principal cause of death and related causes of importance were as follows:  
Fractured skull and brain abscess left frontal lobe  
Other contributory causes of importance: Pulmonary Congestion

Name of operation plastic on nose Date of \_\_\_\_\_  
What test confirmed diagnosis? X-ray Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, fall, or assault? \_\_\_\_\_ Date of injury 11/26/35  
Where did injury occur? K.C. Mo. (Specify city or town, county and State)  
Specify whether injury occurred in industry, in home (or in public place). Public place (street)  
Manner of injury auto accident  
Nature of injury Skull fracture

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_ (Signed) D. P. Turner, Dep. Coroner, M. D.  
(Address) St. Joseph Hosp. Kansas



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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township \_\_\_\_\_ Primary Registration District No. 1002  
City K.C. (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 4758

**2. FULL NAME**

Ronald P. 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 m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
(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	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>35</u>	<u>4</u>	<u>4</u>	

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)

13. NAME

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

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 7.17 19 35 J. J. Brown Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/10 1935

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

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

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

Fracture Skull  
and brain absent 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 auto accident  
Nature of injury \_\_\_\_\_

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

If so, specify \_\_\_\_\_  
(Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

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