

JAN 2 1937

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

9:30 a.m. Do not use this space.

2495

1. PLACE OF DEATH *Burlington*
 County *Burlington* Registration District No. *6286649* File No. *2495*
 Township *Noble* Primary Registration District No. *497201* Registered No. *8*
 City *Squires, Mo.* (No. *1*) St. *Mo.* (Ward)

2. FULL NAME *Alliene Turner*
 (a) Residence, No. *1* St. *Mo.* Ward. *1*
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) *single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct. 14, 1933*

7. AGE YEARS *3* MONTHS *0* DAYS *20* If LESS than 1 day, hrs. or min.

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 *1*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Squires, Mo.*

13. NAME *C.M. Turner*

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

15. MAIDEN NAME *Laura Graham*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mt. Vernon, Mo.*

17. INFORMANT *C.M. Turner* (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE *Murray C.* DATE *11-5* 1936

19. UNDERTAKER *neighbors* (ADDRESS)

20. FILED *11-4* 1936 *Hattie B. Davis* Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov. 11-4* 1936

22. I HEREBY CERTIFY, That I attended deceased from *Oct 25* 1936 to *Nov 4* 1936
 I last saw her alive on *Nov 1* 1936. Death is said to have occurred on the date stated above, at *9:30 p.m.*
 The principal cause of death and related causes of importance were as follows:
Secondary meningitis Date of onset *Oct 20-30*

Other contributory causes of importance:
Enterocolitis

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) *R.M. Norman*, M. D.
 (Address) *awa mo*

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

