

FILED OCT 14 1941

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

Do not use this space.

1. PLACE OF DEATH

County *Whites*
Township *West Dallas*
City *Rogersville R3* (No. *1*)

Registration District No. *901*
Primary Registration District No. *52706210*

File No. *32878/12*
Registered No. *41*
St. _____ Ward _____

2. FULL NAME

Perthena 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widowed</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Tom</i>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Mar. 29 1848</i>				
7. AGE	YEARS <i>93</i>	MONTHS <i>3</i>	DAYS <i>17</i>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Housekeeper</i>			
	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	
MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Tennessee</i>			
	13. NAME <i>Nathaniel Turner</i>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Tennessee</i>			
	15. MAIDEN NAME <i>M^e Pherson</i>			
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Tennessee</i>			
	17. INFORMANT (ADDRESS) <i>R. R. Turner Rogersville, Mo R#3</i>			
	18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Shiloh Cem.</i> DATE <i>July 18 41</i>			
19. UNDERTAKER (ADDRESS) <i>Kelley and Tyrell Rogersville Mo</i>				
20. FILED <i>8-14-41</i> 1941 <i>J. C. Bessore</i> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 16 1941*

22. I HEREBY CERTIFY That I attended deceased from *June 30*, 19*41*, to *July 14*, 19*41*.
That saw her alive on *July 14*, 19*41*. Death is said to have occurred on the date stated above, at *10:10 P.M.*
The principal cause of death and related causes of importance were as follows:

<i>Cerebral Hemorrhage</i>	Date of onset <i>7/13/41</i>
<i>Myocardial degeneration</i>	<i>?</i>

Other contributory causes of importance: *None*

Name of operation _____ Date of _____
What test confirmed diagnosis? *Cholesterol* 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? *No*
If so, specify _____
(Signed) *O. F. Frick M.D.* M. D.
(Address) *Shiloh 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.

RECEIVED

District Health Officer No. 6,

District File Number 104-1586

Date Filed OCT 11 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32878

Registration District No. 901

Primary Registration District No. 6210

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Rogersville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WEBSTER
(c) City or town ROGERSVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. RURAL ROUTE 3
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Perthema J Turner
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July, 1941, day _____, minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____; _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 29, 1848
(Month) (Day) (Year)

8. AGE: Years 93 Months 3 Days 14 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-14-41 (b) T. C. BASSORE
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

1941
S-32878