

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

Do not use this space.

11505

1. PLACE OF DEATH

County Henry
Township Windsor
City Windsor (No. _____)

Registration District No. 14
Primary Registration District No. 14211

File No. _____
Registered No. 15
St. _____ (Ward) _____

2. FULL NAME

(a) Residence. No. _____ 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 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) December-1905

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
22 | 3 | 15

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) Good
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Windsor (STATE OR COUNTRY) Mo

10. NAME OF FATHER Geo. W. Turner

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Windsor (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Rose Acker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Clinton (STATE OR COUNTRY) Mo

14. INFORMANT (Address) Geo. W. Turner Windsor Mo

FILED 7 27 1927 REGISTRAR W. E. Harrison

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 6th 1927

17. I HEREBY CERTIFY, That I attended deceased from 5th 1927 to Apr. 6th 1927 that I last saw her alive on Apr. 6th 1927, and that death occurred, on the date stated above, at 7:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Stroke (caused by accidental automobile injury) that struck her against top of trunk and left her

CONTRIBUTORY (SECONDARY) Injury to right arm and left shoulder (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
NO AT PLACE OF DEATH. no

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. E. Broady M. D.
, 19 (Address) Windsor, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Windsor Mo. DATE OF BURIAL Apr 7 1927

20. UNDERTAKER W. E. Harrison Windsor Mo ADDRESS _____

WHITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

RECORD

WRITE PLAINLY, TO UNFADING

It should be stated that

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

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1. PLACE OF DEATH

County Henry
Township Stender
City Stender (No.)

Registration District No. 14
Primary Registration District No. 4211

File No.
Registered No. 16 St. Ward)

2. FULL NAME Mildred Runner

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>D</u>		4. COLOR OR RACE <u>W</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>S</u>	
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.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employee) (c) Name of employer					
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)					
PARENTS	10. NAME OF FATHER				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)				
	12. MAIDEN NAME OF MOTHER				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 6 1927
17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock caused by accidental automobile truck injury. Craft which struck jockey threw him against top of truck violently.

CONTRIBUTORY (SECONDARY) injury to right arm and right shoulder (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRIBUTORY? Accident occurred at Stender, Missouri
(IF NOT A PLACE, STATE THE PLACE)

DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? 1880
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

14. INFORMANT (Address) [Signature]
15. FILED 7 19 27 [Signature] REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19
20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

SUPPLEMENT

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