

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

Do not use this space.

11598

1. PLACE OF DEATH

County Monroe
Township Woodlawn
City Leasburg (No. _____) St. _____ Ward _____

Registration District No. 587
Primary Registration District No. 1585

File No. _____
Registered No. _____

2. FULL NAME

(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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 23-1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
61 0 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Moses Turner

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

12. MAIDEN NAME OF MOTHER Ellen Sanner

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

14. INFORMANT Tom Overfelt
(Address) D. Stewart Buder

15. FILED May 27 1927 To Meddley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 7 1929

17. HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to Mar. 7, 1929, that I last saw h. alive on Mar 7, 1929, and that death occurred, on the date stated above, at 10 ce m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
preceded and accompanied
with heart lesion

CONTRIBUTORY (SECONDARY) NO (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. A. Syatt, M. D.

, 19 29 (Address) Clarence 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 Phillips Cemetery DATE OF BURIAL Mar 17-29

20. UNDERTAKER E. Hopper ADDRESS Clarence Mo.

Year 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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