

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.

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

791  
1008

Do not use this space.

29750

**1. PLACE OF DEATH**

County ..... Registration District No. ....  
Township ..... Primary Registration District No. ....  
City St. Louis Mo. (No. City Hospital #2) St. .... Ward .....

File No. ....  
Registered No. 8785  
St. .... Ward .....

**2. FULL NAME**

(a) Residence, No. 1235 N. Lakeside St. M Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Coe</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>3-16-1885</u>		
7. AGE	YEARS <u>46</u>	MONTHS <u>4</u>
	DAYS <u>28</u>	IF LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as splinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	<u>unknown</u>
	10. Date deceased last worked at this occupation (month and year)	<u>unknown</u>

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

13. NAME Walker Turnley

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

15. MAIDEN NAME Francis Cross

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT A. K. ... (ADDRESS) City Hospital #2

18. BURIAL, CREMATION, OR REMOVAL Washington Park cemetery PLACE DATE 8/17 1931

19. UNDERTAKER Dunn Bros (ADDRESS) 215 S. Jefferson

20. FILED AUG 16 1931 W. C. ... Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-14 1931

22. I HEREBY CERTIFY, That I attended deceased from 6-23 1931 to 8-14 1931  
I last saw him alive on 8-14 1931. Death is said to have occurred on the date stated above, at 7:45 p.m.  
The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis 4 years  
Other contributory causes of importance:  
None

Name of operation ..... Date of .....  
What test confirmed diagnosis? 9/26 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? .....  
If so, specify C. M. Smith (Signed) City Hospital #2 M. D.  
(Address) .....

