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.

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

PLACE OF DEATH

County Barry

Township ~~Pleasant Ridge~~ Registration District No. 928 File No. 1 100

or Village McDonald Primary Registration District No. 5085B. Registered No.

or City (NO. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Bertha Hillesa Turrell

PERSONAL AND STATISTICAL PARTICULARS

SEX Female ~~white~~ | COLOR OR RACE white | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Jan (Month) 27 (Day), 1918 (Year)

AGE yrs. 7 mos. 14 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

BIRTHPLACE (City or town, State or foreign country) McDowell MO

NAME OF FATHER Gory Turrell

BIRTHPLACE OF FATHER (City or town, State or foreign country) McDowell MO

MAIDEN NAME OF MOTHER Nora Bolton

BIRTHPLACE OF MOTHER (City or town, State or foreign country) McDowell MO

PARENTS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hoy Turrell

(ADDRESS) McDowell MO

Filed Feb 10 1918 S. J. Robertson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan (Month) 27 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 26, 1918, to Jan 27, 1918, that I last saw her alive on Jan 27, 1918, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria

10

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. 2 ds.

(Signed) S. J. Robertson M. D.

Jan 28, 1918 (Address) McDowell MO

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Clifton County | DATE OF BURIAL Jan 28 1918

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.

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

PLACE OF DEATH

County ______

Township ______ Registration District No. ______ File No. ______
or
Village ______ Primary Registration District No ______ Registered No. ______
or
City ______ (NO. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ______

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH ______ (Month) (Day), 1 ______ (Year)

AGE ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ______ hrs, or ______ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ______
(b) General nature of industry, business, or establishment in which employed (or employer) ______

BIRTHPLACE (City or town, State or foreign country) ______

PARENTS

NAME OF FATHER ______

BIRTHPLACE OF FATHER (City or town, State or foreign country) ______

MAIDEN NAME OF MOTHER ______

BIRTHPLACE OF MOTHER (City or town, State or foreign country) ______

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ______

(ADDRESS) ______

Filed ______, 191 ______, ______ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ______ (Month) (Day), 191 ______ (Year)

I HEREBY CERTIFY, that I attended deceased from ______, 191 ______, to ______, 191 ______, that I last saw h ______ alive on ______, 191 ______, and that death occurred, on the date stated above, at ______ m.

The CAUSE OF DEATH* was as follows:

______

______ (Duration) ______ yrs. ______ mos. ______ ds.

Contributory ______ (SECONDARY)

______ (Duration) ______ yrs. ______ mos. ______ ds.

(Signed) ______ M. D.

______, 191 ______ (Address) ______

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ______ yrs. ______ mos. ______ ds. In the State ______ yrs. ______ mos. ______ ds.

Where was disease contracted if not at place of death? ______

Former or usual residence ______

PLACE OF BURIAL OR REMOVAL ______ | DATE OF BURIAL ______, 191 ______

UNDERTAKER ______ | ADDRESS ______